**BALANCED LIVING AYURVEDA**

1598 Old Oak Park Rd; Arroyo Grande
Phone: (805) 773-1457 or (805) 440-4561; Fax: (805) 773-1900

# CONFIDENTIAL CLIENT HISTORY

*Client's Name:* ______________________________________________

*Client's Address:* ____________________________________________

*City, State, Zip:* _____________________________________________

*Telephone—Home:* ______________ *Cell:* _________________ *Work:* ______________

*E-mail:* ________________________________ *Birth date:* __________ *Age:* ______

*Marital/partner status:* _____________ *# of children:* _____________ *Ages:* ____________

**Is there a possibility that you are pregnant?* q*Yes* q*No* q*Possible*

*Occupation:* __________________________________________________

*How did you hear about Balanced Living Ayurveda?* ______________________________

## PAST MEDICAL HISTORY

Include major conditions, dates of treatment and procedures performed.

*1. Serious illnesses:* _______________________________________________

_____________________________________________________________

*2. Hospitalizations:* _______________________________________________

*3. Operations:* ___________________________________________________

*4. List other pertinent past conditions:* ________________________________

_____________________________________________________________

*5. Have you been under the care of a licensed health care professional in the past year?* q***Yes*** q***No***

*If so, for what reasons:* ____________________________________________

*6. Eating Disorders:* _______________________________________________

*7. Have you had any cosmetic surgery or procedures performed?* q***Yes*** q***No***

*If so, please list:* _________________________________________________

## FAMILY HISTORY

Please check the appropriate boxes and indicate family member.
If adopted, answer according to family heritage, if known.

| | |
|---|---|
| q *Cancer* | q *Diabetes* |
| q *High Blood Pressure* | q *Heart Disease* |
| q *Stroke* | q *Mental Disorder* |
| q *Other (explain)* | q *Other (explain)* |

**WHAT IS THE PRIMARY REASON FOR TODAY'S VISIT?**

**CHIEF HEALTH CONCERNS:**

Please list your primary concerns, both physically and mentally/emotionally.

1.

2.

3.

4.

Did you have any health issues as a child? If so, please briefly describe.

Have you experienced significant events or life occurrences in the recent past? (i.e. marriage, divorce, death of family member?)

## INFORMED CONSENT

Complementary or Alternative Health Care through BALANCED LIVING Ayurveda

All clients who participate in Ayurvedic health care through this program should be advised of the following information:

1. Ayurveda is the traditional healing system of India, which is based on the idea that each person's path toward optimal health is unique. Your program is based on understanding your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other natural therapeutics. The goal of all programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.
2. Holly Padove is not a medical doctor.
3. Holly Padove is not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
4. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003.
5. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If Holly Padove refers you to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
6. Holly Padove will not recommend altering your prescriptions without the approval of your medical doctor. I may suggest that you speak to your doctor about reducing medication when he/she feels that it is appropriate.
7. While I may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, I am evaluating the findings from an Ayurvedic perspective only and not from a Western medical perspective. **This examination does not take the place of a medical evaluation.** If, as a result of your examination, any findings suggestive of a possible medical imbalance is found, I will refer you to a Medical Doctor for further evaluation.

I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with Holly Padove of Balanced Living Ayurveda.

Client's Signature: ____________________________________________Date: _____________

## FINANCIAL POLICY AGREEMENT

*1. There is a $150 charge for each initial consultation with your Clinical Ayurvedic Specialist. Herbs are separate.*

*2. There is a $85 charge for each one-hour follow-up visit with your Clinical Ayurvedic Specialist.*

*3. Balanced Living Ayurveda does not bill insurance companies for services or herbs.*

*4. If you miss an appointment without giving 24 hours notice, a $10.00 fee is charged to your account.*

*I have read and understood the financial policies of the Balanced Living Ayurveda.*

***Client's Signature:***

CLIENT NAME:_____________________________________

# CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

*What medications, herbs, supplements are you currently taking?*
*Please include significant remedies that you have recently stopped taking.*
*Please also include birth control and hormone replacement therapy.*

| **Substance** | Over-the-counter/ Prescription? | Herb/Drug/ Vitamin? | Prescribed by? | For what purpose? | Taken for how long? | What is your current dosage? | What have been the benefits? |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

***Page a b c d***

*CLIENT NAME:* ______________________

# ***DAILY ROUTINES***

*To be filled out by client*

## ***DAILY SCHEDULE*** *(include approximate times)*

*1. Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, recreation).*

| | Time | Activities | |
|---|---|---|---|
| **MORNING**<br>Awaken | | (i.e. shower, etc.) | **VARIATIONS (i.e. weekends)** |
| Breakfast | | Do you do anything during breakfast? | |
| Morning Activities | | | |
| **Afternoon**<br>Lunch | | Do you do anything during lunch? | |
| Afternoon Activities | | | |
| | | | |
| **Evening**<br>Dinner | | Do you do anything during dinner? | |
| Evening Activities | | | |
| Bed-time | | Any typical routines prior to bedtime? | |
| | | | |

2. List regular practices that are not included in the above schedule, e.g., exercise, meditation, spiritual practices, etc.

_______________________________________________

_______________________________________________

3. What do you do for recreation/fun, and how many times per week?

_______________________________________________

_______________________________________________

4. Sexual activity: How often are you engaging in sexual activity?

Total times per week/per month: ________________________

4. Other comments about daily routines: _______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

## DAILY ROUTINES

*To be filled out by client*

5. What types of food(s) are eaten on a regular basis?

| BREAKFAST | LUNCH | DINNER | SNACKS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

6. Are there any routines around eating: ____________________________________________

7. Any current problems with chronic eating disorders or other food related issues? q **Y** q **N**

Comments: ____________________________________________

### *ALLERGIES OR SENSITIVITIES*

8. Do you have allergic reactions to any substances? If yes, please list.

____________________________________________

____________________________________________

### *GENERAL HEALTH HABITS*

9. How many cups of caffeinated beverages do you drink per day?

# ______________________ *Type(s) of beverage: coffee/tea/soda*

10. How many cups of non-caffeinated beverages do you drink per day?

# ______________________ *Type(s) of beverage: herbal tea/milk/juice/other*

11. How much water do you drink per day? ____________________________________________

12. Do you exercise regularly? q Y q N

*Length of time:* ______________________ *Times per week:* ______________________

*Type(s) of exercise:* ____________________________________________

13. If you smoke, how many cigarettes do you smoke per day? ______

*Have you ever smoked?* q Y q N *Amount/day:* ____________ *When quit?* ______________

14. If you drink alcohol, how many glasses of alcohol per week? *(Include beer, wine, liqueurs and hard liquor)*

# ________________*per week* *Type(s) of beverage:* ______________________

15. Any current or past use of addictive substances? q Y q N

*Substance:* ______________________ *Amount:* _________ *When quit?* __________

*CLIENT NAME:*______________________________________

*Please check the digestive, elimination and emotional challenges that you experience. These are very important to understanding you from an Ayurvedic perspective. Then list any other significant symptoms that you are concerned about and wish to discuss with your practitioner. Finally, if you have been diagnosed with any disease or condition, please list these as well.*

**(1) DIGESTION**

| | |
|---|---|
| | Abdominal pain |
| | Belching |
| | Regurgitation |
| | Gas |
| | Burning indigestion |
| | Vomiting |
| | Nausea |
| | Heavy after eating |
| | Sleepy/low energy after eating |
| | Bloaty after eating |

**(2) ELIMINATION**

| | |
|---|---|
| | Constipation (<1bm/day) |
| | Both constipation and diarrhea |
| | Food particles in stool |
| | Rectal pain |
| | Diarrhea |
| | Bloody stool |
| | Mucus in stool |
| | Unusual color in stool |

**(5) PSYCHOLOGY**

| | |
|---|---|
| | Worry |
| | Anxiety/Fear |
| | Overwhelm |
| | Spaceyness |
| | Insomnia |
| | Self-destructive |
| | Irritable |
| | Anger |
| | Resentment |
| | Jealousy/Envy |
| | Being critical |
| | Intense |
| | Lethargy |
| | Sadness |
| | Depression |
| | Greediness |
| | Other |

**(3) ADDITIONAL SYMPTOMS OF CONCERN**

______________________________

______________________________

______________________________

______________________________

______________________________

**(4) DIAGNOSED CONDITIONS**

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

**PRACTITIONER USE ONLY**

| (Record each symptom on this page, in order, on the Detailed Symptoms Summary form.) |
|---|
| |
| |
| |
| |
| |
| |