Healing Herbs

AYURVEDIC FORMULATIONS LLC

Health Assessment Form

Today's Date:		Age:	
Gender:		Name (Last, First, MI):	
Height:		Weight:	
Address (No. Street):		Date of Birth:	
City		Phone:	
State		E-mail:	
Zip Code		Occupation:	

Marital Status?

☐Married
☐Divorced/Separated
☐Widowed
☐Single
☐Cohabitating

Emergency Contact Name: **Phone:**	**Referred by:**

What is your ethnicity?

☐ Native American
☐ Mediterranean
☐ Caucasian
☐Asian
☐African American
☐Northern European
☐Hispanic
☐South Asian
☐Other

With whom do you live? Include children, parents, other occupants, and pets with ages

What do you hope to achieve with your health consultation today?

Main problem(s) you would like help with

Describe problem	Start date	Mild/Moderate/Severe	Attempted treatment and response

Mild – some discomfort, Moderate – creates much trouble, but can continue regular activities, severe – restricts your daily routine

Are you diagnosed with any medical conditions?

Conditions	Start date	Control status	Treating physician, affiliation

Are you taking any prescription medications?

Medication Name	Start date	Dosage	Prescribed by

Are you taking any herbal or alternative medicine?

Name	Start date	Dosage	Prescribed by

Are you taking any vitamins or nutritional supplements?

Name with dose of main ingredients	Start date	Regularity	Given by

e.g., One a Day, Centrum, other vitamins

Family History Fill only the positive yes as 'Y' or a tick mark

	Father	Mother	Brother(s)	Sister(s)	PGM	PGF	MGM	MGF
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroid	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐
If not living, Age of and cause of death	☐	☐	☐	☐	☐	☐	☐	☐

PGM, PGF = Paternal grandmother, grandfather; MGM, MGF =maternal grandmother, grandfather

Were there any diseases that you suffered from earlier?

Disease	Start and end date	Treatment – drugs, exercise, etc.

Include major infections like typhoid, malaria, hepatitis

Have you had any kind of surgery or minor procedures performed on you?

Procedure	Date	Who and where was it performed

Include any Panchakarma, Acupuncture and other treatments here as well

Please list any hospitalizations

Year	Condition	Procedure done

How much do you physically move your body?

Activity	Intensity	Hours	Days/Weeks	Start date
How often do you break a sweat with exercise? (times/week)				
How many hours do you watch TV every week?				
Do you watch TV, read or surf while eating meals?				

Do you connect with yourself? How and how often?

Hobbies/music/ meditation/ community service etc.

What is your energy level?

0 – very poor, I can barely get through the day, 10–excellent, I can do more

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Input information about the Rogi's diet and everyday routines.

General/Daily Fating Pattern

	Time	Solids	Liquids with meal
Breakfast			
Snack			
Lunch			
Dinner			
Dessert			

Appetite:

Water Intake:

Rate on a scale of 1-5 how the following applies

If 1= Always, 2= Often, 3=Sometimes, 4=Rarely, 5=Never

	Rate	*If 3 or below, it indicates*
Is the above pattern mentioned irregular?		*Vata (Vishama)*
Can you skip meals easily?		*Kapha/Ama (Manda)*
Are you mostly always ready to eat – whatever the time of the day it maybe?		*Pitta (Tikshna)*
If hunger is not gratified, do you feel uncomfortable or Irritable?		*Pitta (Tikshna)/ (Vata)*
Do you end up feeling fuller earlier than expected at the start of a meal?		*Ama/ Vata (Manda/Vishama)*
Are there times when even little quantity of food doesn't get digested for a long time?		*Ama (Manda)*
Does your food get digested well on some days and sometimes not?		*Vata (Vishama)*

Habits: *Please indicate usage: none, light, moderate, or heavy. Add comments where significant.*

	Heavy	Moderate	Light	None	Comments
Alcohol	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Tea	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Marijuana	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Personal Preferences

Which weather do you prefer?	Warm / cool/ both ☐ ☐ ☐
Which extreme of weather are you unable to tolerate?	Hot / Cold / Neither ☐ ☐ ☐
Which taste do you prefer?	Sweet/ Sour/ Salty/ Hot/ Bitter/ Astringent ☐ ☐ ☐ ☐ ☐ ☐
How thirsty do you feel?	Often/ Moderate/ Not much ☐ ☐ ☐
Do you sweat easily?	Often/ Not that much/ rarely ☐ ☐ ☐

General Lifestyle

	Weekdays	Weekends
Wake up time		
Bedtime		
Naps		

Overall Sleep Quality

Description of daily activities

Stress Level

General

☐Poor appetite
☐Sudden energy drop
☐Chills
☐Poor sleep
☐Peculiar tastes/smells
☐Localized weakness
☐Sweat easily
☐Weight gain
☐Cravings
☐Time(s) of day: _____
☐Tremors
☐Fatigue
☐Strong thirst – hot
☐Bleed/bruise easily
☐Fevers
☐Weight loss
☐Change in appetite
☐Poor balance
☐Night sweats
☐Strong thirst – cold

Skin and Hair

☐Rashes
☐Change in texture
☐Recent moles
☐Other skin/hair problems:
☐Skin tags
☐Hives
☐Loss of hair
☐Itching
☐Pimples
☐Dandruff

Head

☐Dizziness
☐Headaches
☐Facial pain
☐Other head/neck problems:
☐Migraines

Eyes, Ears, Nose and Throat

☐Glasses
☐Eye strain
☐Color blindness
☐Ringing in ears
☐Nose bleeds
☐Grinding teeth
☐Jaw clicks
☐Poor vision
☐Night blindness
☐Eye pain
☐Poor hearing
☐Sinus problems
☐Sore throat (recurrent)
☐Cataracts
☐Blurry vision
☐Spots in vision
☐Earaches
☐Teeth problems
☐Sores on lips/tongue

Cardiovascular

☐Swelling of feet
☐Low blood pressure
☐Difficulty breathing
☐Irregular heartbeat
☐Chest pain
☐Fainting
☐Dizziness
☐Venous swelling
☐Blood clots
☐Cold hands
☐Swelling of hands
☐Cold feet
☐Other heart/blood vessel

Respiratory

☐Cough
☐Coughing blood
☐Pain with deep breath
☐Difficulty lying down
☐Phlegm color:
☐Other

Musculoskeletal

☐Neck pain
☐Back pain
☐Shoulder pain
☐Hand/wrist pain
☐Hip pain
☐Knee pain
☐Foot/ankle pain
☐Other muscle pain
☐Muscle weakness

Gastrointestinal

☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Gas
☐Belching
☐Indigestion
☐Bad breath
☐Blood in stools
☐Black stools
☐Abdominal pain/cramps
☐Chronic laxative use

Genito-Urinary

☐Frequent urination
☐Urgency to urinate
☐Kidney stones
☐Pain on urination
☐Unable to hold urine
☐Impotency
☐Blood in urine
☐Decrease in flow
☐Excessive sexual urge
☐Do you wake up to urinate, how often?

Neuropsychological

☐Lack of coordination
☐Stress sensitivity
☐Areas of numbness
☐ Emotional treatment history
☐Depression
☐Bad temper
☐Poor memory
☐Anxiety
☐Seizures
☐Concussion
☐Dizziness
☐Loss of balance
Other: _____

Pregnancy and Gynecology

☐Painful periods
☐Clots
☐Irregular periods
☐Vaginal discharge
☐Vaginal sores
Breast lumps
☐Premenstrual symptoms
☐Unusual character (heavy/light)
☐Use birth control
Type: _____
How long: _____
☐No. of pregnancies: _____
☐No. of births: _____
☐No. of premature births: ____
☐No. of miscarriages: _____
☐No. of abortions: _____
☐Age at first menses: _____
☐Date of last menses: _____
☐Menses duration: _____
☐Length of full cycle: _____
☐Date of last PAP: _____

Bowel Movement Assessment

1. *Frequency & Timing:*
    - What time do you typically have a bowel movement?

2. *Ease of Movement:*
    - Do you need to strain for a bowel movement to happen?

    ☐Always ☐Often ☐Sometimes ☐Rarely ☐Never

    - How often do you have a bowel movement?

    ☐Daily☐ Every other day ☐ Less than 3 times a week ☐ More than once a day

3. *Post-Movement Feeling*

    - How do you feel after a bowel movement?

    (Rate on a scale of 1 to 10, where 1 = very heavy and 10 = very light)

4. *Supportive Measures:*
    - Do you take any medications, like Dulcolax or other stool softeners, to have a bowel movement?

    ☐ Yes ☐ No

    If yes, please list them and how often:

5. *Dietary or Lifestyle Factors:*
    - Do you consume specific foods or beverages to aid bowel movements?*(e.g., warm water, fiber-rich foods, herbal teas)*

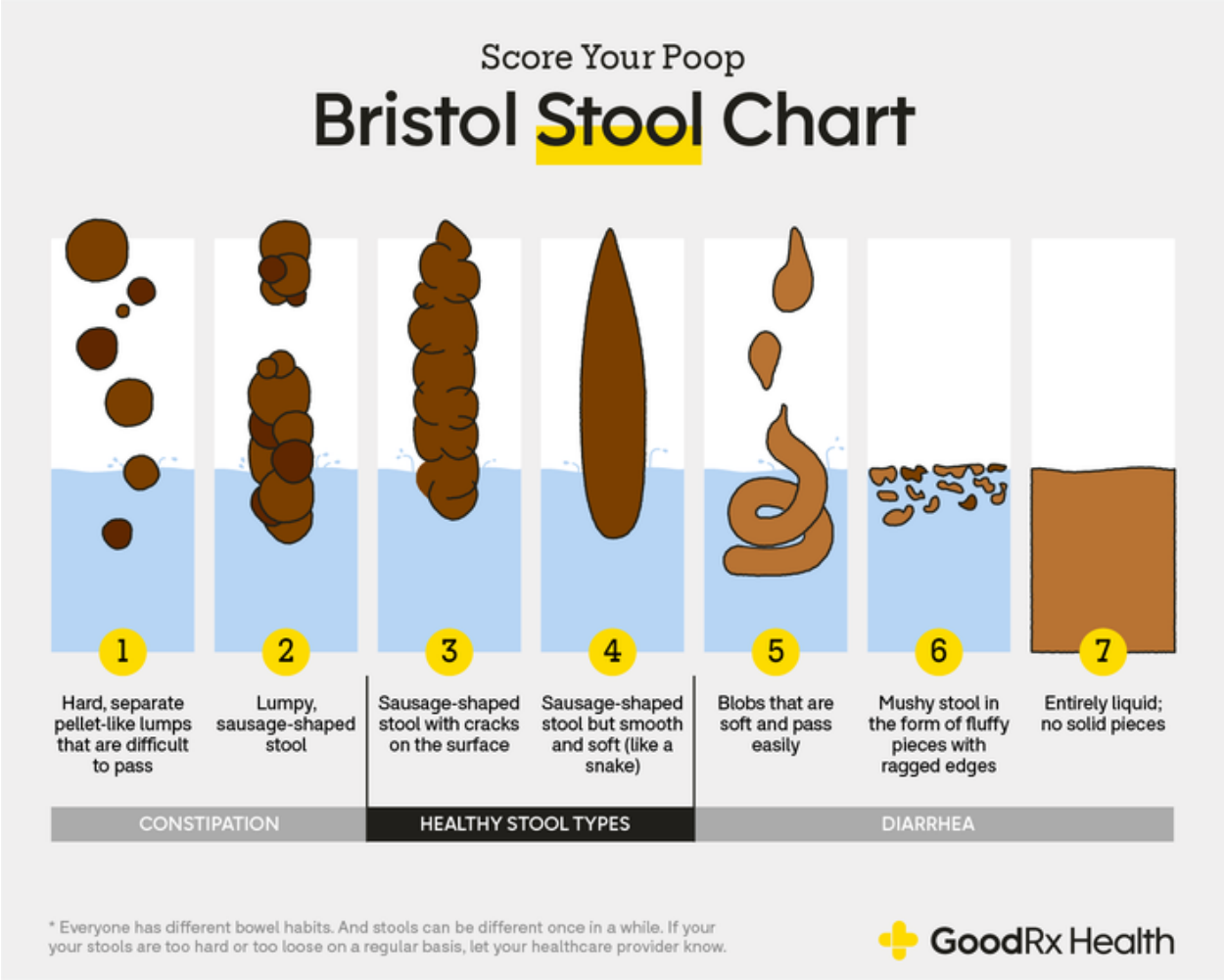
    ☐ Yes ☐ No

    If yes, please describe:

6. *Consistency & Frequency:*
    - How would you describe the consistency of your stool?

    ☐ Hard ☐ Firm ☐ Soft ☐ Loose ☐ Other: _____

Select an image that applies



☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐ 7

7. *Additional Observations*

- Do you notice any unusual characteristics (*e.g., color, odor, mucus, blood*)?
  ☐ Yes ☐ No
  If yes, please describe:

HIPA Compliance Notice

Effective Date: _____

At Healing Herbs Ayurvedic Formulations LLC, we prioritize the confidentiality and security of your personal health information. This notice explains how your health information is used and your rights regarding its management.

We maintain medical records of the wellness services we provide for you.

You have the right to:

- View and copy your records.
- Request corrections to your records.

Your records will remain confidential unless:

- You provide written permission to release them.
- We are required by law to disclose them.

We will request your signed consent to use and disclose your health information for purposes such as:

- Consultations.
- Payment processing.
- health technique operations

You may contact our office to view your records or inquire further about our privacy practices.

By signing below, I acknowledge that I have received and reviewed the HIPAA Notice of Privacy Practices provided by Healing Herbs Ayurvedic Formulations LLC. I understand how my personal health information may be used and disclosed, and I am aware of my rights to access and manage my records.

Signature: _____

Date: _____

☐ By checking this box, I certify that typing my name is equivalent to my signature.

Healing Herbs

AYURVEDIC FORMULATIONS LLC

Scope of Ayurveda Notice

Name: _____
Date: _____

Welcome to Healing Herbs Ayurvedic Formulations LLC! We are dedicated to supporting your holistic wellness journey through the ancient wisdom of Ayurveda. At Healing Herbs, we focus on connecting people with nature to nurture the body, mind, and spirit using personalized Ayurvedic guidance and handcrafted products.

Please note the following:

- We are Ayurvedic consultants and not licensed physicians. Ayurvedic services are not licensed by the state.
- Ayurveda is a 5,000-year-old system of natural healing that emphasizes maintaining harmony and balance in the body, mind, and spirit through diet, lifestyle, and natural herbs.
- Ayurvedic treatments are individualized and tailored to meet the unique needs of each person.

Our Services Include:

- Body-Constitutional Analysis: Understanding your dosha and unique constitution to provide personalized recommendations.
- Diet and Lifestyle Counseling: Guiding you towards Ayurvedic practices for balanced living.
- Ayurvedic Body Techniques: Suggestions for body care and natural practices to support wellness.
- Yoga and Meditation Practices: Recommendations for yoga and pranayama practices based on your dosha.

Our method of treatment in Ayurveda is complementary or alternative to conventional medicine. If you have any concerns regarding Ayurvedic practices, please feel free to discuss them with us. We recommend informing your medical doctor if you are receiving Ayurvedic advice or using Ayurvedic products.

Consent and Acknowledgment

By signing below, I confirm that:

- I have read and understood the above disclosure about the Ayurvedic services offered by Healing Herbs Ayurvedic Formulations LLC.
- I understand that the Ayurvedic consultant is not a licensed physician and that Ayurvedic services are not licensed by the state.
- I acknowledge that it is my responsibility to maintain a relationship with a licensed medical doctor for any medical concerns.

Signature: _____

Date: _____

☐ By checking this box, I certify that typing my name is equivalent to my signature.

Missed Appointment Notice

We kindly request your cooperation in adhering to our cancellation policy to ensure smooth scheduling and availability for all clients.

- Please provide at least 48 hours' notice for canceling an initial appointment and 24 hours' notice for canceling a follow-up appointment. This allows us to accommodate other clients who may be waiting for an appointment.
- Unavoidable emergencies will be considered reasonable exceptions.
- Please note that we allocate a specific amount of time for each consultation and treatment. If you arrive late, the length of your session may need to be adjusted to fit the schedule.
- NOTE: For Monday appointments, cancellations must be made no later than 6:00 PM on the preceding Friday.
- A $50.00 fee will be charged for missed appointments without adequate notice.

Acknowledgment of Cancellation Policy

By signing below, I confirm that:

1. I have read and understood the cancellation and missed appointment policy of Healing Herbs Ayurvedic Formulations LLC.
2. I agree to the terms outlined above, including the $50.00 fee for missed appointments without proper notice.

Signature_____ Date: _____

☐ By checking this box, I certify that typing my name is equivalent to my signature.

Name_____

Signature of Parent or Legal Guardian_____