North State Ayurveda

nutrition . lifestyle . beauty

530.604.4050

Welcome!

Thank you for considering North State Ayurveda for your holistic health care needs.

Enclosed in this packet is information about the Consultation Service including several forms that will help us understand why you are seeking complementary medicine.

The Consultation Intake Packet includes:

- A Brief Introduction to Ayurveda
- Ayurveda Intake Form / Informed Consent
- Personal Health Information and History
- Financial Policy Agreement

Before you complete the forms, please look over the entire packet to familiarize yourself with what will be asked. Then, complete all forms as thoroughly as you can and return them to North State Ayurveda. Please keep this cover letter and the Introduction to Ayurveda for your records.

Thank you for taking the time to provide the information requested. We look forward welcoming you for your initial consultation and assisting your journey through mind-body medicine.

In health,

Whitney Kenney
Ayurveda Wellness Counselor
Panchakarma Specialist and C.M.T.

Introduction to Ayurveda

Ayurveda translates to "Science of Life". It is the medicinal system of India and the sister science to Yoga. Ayurveda focuses on the complete individual person for healing, including mind and spirit. Western Medicine tends to focus on symptomatic health care, whereas Eastern (or Complementary) Medicine states that for complete wellness to occur, the body, mind and spirit must be in harmony with each other and naturally resilient to conditions causing dis-ease.

Ayurveda defines wellness not as the absence of defined disease, but when all bodily tissues, organs, systems and functions are acting together in a healthy way and are able to maintain health and wellness in spite of potential illness causing influences. Ayurveda believes that by balancing the various mind-body functions, the natural intelligence of the body will bring itself to wellness.

Ayurveda uses natural processes and methods whenever possible for bringing wellness and restoring good health. Western medicine often attempts to restore health by treating the symptoms of the body or by attacking the disease, using artificial drugs and medicines to treat symptoms and diagnoses. Ayurveda is complementary to traditional medical practices and does not replace medical diagnosis and treatment.

Ayurveda recognizes that each person has a unique mind-body constitution. Ayurveda then identifies various components of that individual's constitution, determines where imbalances and disturbances exist, and gives guidance to create lifestyle changes that will benefit health and well-being.

Ayurvedic practices focus on detoxification and purification of metabolic and energetic patterns that support constitutional resilience. It is the implementation of the correct Ayurvedic practices that bring balance and wellness. When mind, body and spirit are in a disrupted state we are more vulnerable to developing pathological illness and disease. Ayurveda will help improve health through small shifts in lifestyle habits.

The National Institute of Health, Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States. 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. Ayurvedic consultations are considered alternative or complementary to medical practices that are licensed by the State of California.

North State Ayurveda works with clients through a collaborative planning process. Collaborative planning is a process for developing an understanding between you and North State Ayurveda for specific services, including:

- North State Ayurveda contributing to achieve your health and wellness objectives
- Client having appropriate tools to achieve health and wellness objectives
- Working together to facilitate your plan for health and wellness

INFORMED CONSENT

to receive Complementary Health Care through

North State Ayurveda

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

1. Ayurveda is the traditional healing system of India and is based on the idea that the path to optimal health is unique to each individual. Your program is based on your unique constitution and the unique nature of your imbalance and may include: lifestyle adjustments, dietary changes, herbs, aromatherapy, massage therapy and other natural therapeutics. The goal of all programs is to create within your body and mind an optimum environment for healing and to maximize your ability to heal yourself.
2. North State Ayurveda is not a Primary Care Medical Clinic.
3. Employees of North State Ayurveda are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
4. The National Institute of Health, Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States. 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. Ayurvedic Consultations are considered complementary to practices licensed by the State of California.
5. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or other licensed health care professional, you must be evaluated by a Medical Doctor. If you choose not to see a Medical Doctor, you will be required to sign an acknowledgment that one was recommended to you.

I have read and understand the above information and give my permission to begin a program of Ayurvedic Health Care with North State Ayurveda.

Client's Signature: _____ Date:

_____

AYURVEDA INTAKE FORM

Please initial each statement:

I understand that this is an Ayurvedic Consultation for the purpose of helping me improve my health and wellness. I understand this does not include medical diagnosis or treatment and is not a substitute for medical care. _____

I understand that Whitney Kenney is an Ayurvedic Consultant and Educator who provides me with information on the Ayurvedic approach to health care, which may affect my diet and health in a positive way. _____

I understand that Whitney Kenney is not a Medical Doctor and has not presented herself as such. _____

I agree that I am interested in enhancing my own abilities to heal and establish a health in mind and body. _____

Signature: _____ Date:

_____

CONFIDENTIAL CLIENT HISTORY

Name: _____

Address: _____ City, State, Zip:

_____

Phone: _____ Email:

_____

Birth date: _____ Age: _____ Height: _____ Weight:

_____

Partner Status: _ Single _ Partnered _ Married _ Separated _ Divorced _ Widowed

Number of Children: _____ Ages: _____ Occupation:

_____

Referred By:

_____

Primary Care Doctor:

_____

OBJECTIVES

1. Please check the items that reflect your main objectives:

- ❑ I want an alternative approach to allopathic medicine for managing illness and disease
- ❑ I want to improve my general health and wellness to reduce my vulnerability to illness and disease
- ❑ I want to improve my lifestyle and dietary practices to improve my health
- ❑ I want to change my habits and behavioral patterns to improve my relationships with others
- ❑ I want to manage stress, tension and worry to attain a more stable emotional nature

2. What do you want to achieve or change in terms of your health and wellness?

_____

_

_____

_

3. How would your life be different if you were to achieve these objectives to your satisfaction?

_____

_____

___

CURRENT CONCERNS

4. What are the major concerns that have brought you to this office today?

_____

_____

___

5. When did this begin?

_____

6. Has anything recently changed or become worse?

_____

__

7. Have you had a diagnosis? If so, what was it?

_____

__

8. Are you currently receiving care from any other health professional?

Name:

_____

For what condition:

_____

9. Have you been under the care of a licensed health care practitioner in the past year? _ No _ Yes

If yes, for what reasons:

_____

Date of last physical exam:

_____

10. Date of last dental visit: _____ Date of last eye exam:
_____

11. Do you see a chiropractor, massage therapist or acupuncturist? _ No _ Yes

Name:

_____

12. Other significant symptoms:

_____

__

13. Other diagnosed conditions and date diagnosed:

_____

__

PAST HEALTH CONDITIONS

14. Serious illness, hospitalizations, operations / dates:

_____

_____

____

15. Trauma: Have you ever had a car accident, a bad fall, etc. / date and description:

_____

_____

____16. Have you ever been unconscious? _ No _ Yes

17. Have you ever had a blood transfusion? _ No _ Yes

18. Have you been diagnosed with an infectious disease? _ No _ Yes

19. Childhood illnesses: _ Measles _ Mumps _ Rubella _ Chickenpox _ Rheumatic Fever _ Polio

20. Were you breast-fed as a child: _ No _ Yes / If yes, for how long?

_____

CURRENT HEALTH CONCERNS

Please read these instructions carefully.

Indicate any physical and emotional patterns that you have had **in the last 3-6 months**.
Assign a LETTER and NUMBER to each of the following conditions, for diagnosis please give date diagnosed.

F=Frequency (letter)

C= Constant
D= Daily
W= Weekly
M= Monthly

I=Intensity (number)

1-3= Mild discomfort
4-7= Moderate discomfort
8-10= Severe discomfort

Frequency / Intensity

DIGESTION

Abdominal pain____ / ____
Excessive gas ____ / ____
Belching ____ / ____
Bloating ____ / ____
Food cravings ____ / ____
Poor appetite ____ / ____

Burning indigestion____ / ____
Heartburn ____ / ____
Acid reflux ____ / ____
Smelly gas ____ / ____
Ulcers ____ / ____
Intestinal bleeding ____ / ____

Nausea____ / ____
Vomiting____ / ____
Difficulty swallowing____ / ____
Sluggish after eating____ / ____
Sleepy after eating____ / ____
Full after eating small portion____ / ____

ELIMINATION

Constipation ____ / ____
Some diarrhea ____ / ____
Rectal pain ____ / ____
Food in stool ____ / ____
BM changes ____ / ____

Diarrhea ____ / ____
Loose stool ____ / ____
Bloody stool ____ / ____
Black/colored stool____ / ____
Hemorrhoids ____ / ____

Mucus in stool____ / ____
BM after meal only____ / ____

STATE OF MIND

Worry ____ / ____
Anxiety ____ / ____
Fear ____ / ____
Overwhelm ____ / ____

Irritable ____ / ____
Anger ____ / ____
Rage ____ / ____
Resentment ____ / ____

Lethargy____ / ____
Sadness____ / ____
Depression____ / ____
Greediness____ / ____

STATE OF MIND (continued)

Daydreamer ____ / ____
Insomnia ____ / ____
Indecisive ____ / ____
Seizures ____ / ____
Loss of balance____ / ____
Poor memory ____ / ____

Jealousy ____ / ____
Envy ____ / ____
Critical of others ____ / ____
Critical of self ____ / ____
Intense ____ / ____
Sharp ____ / ____

Over-attachment____ / ____
Grief____ / ____
Procrastination____ / ____
Foggy feeling____ / ____
Numbness____ / ____
Poor mental clarity____ / ____

Headaches ____ / ____
Panic Attacks ____ / ____
Lack of coordination____ / ____
Difficulty concentrating____ / ____

SKIN AND HAIR

Dry Skin ____ / ____
Itching ____ / ____
Rashes ____ / ____
Hives ____ / ____
Bruise easily ____ / ____
Poor healing sores ____ / ____
Eczema ____ / ____
Psoriasis ____ / ____
Dandruff ____ / ____
Pimples____ / ____
Moles____ / ____
Excessive Sweating____ / ____

EARS

Poor hearing ____ / ____
Earaches ____ / ____
Ear pain ____ / ____
Ringing in ears ____ / ____
Ear infections____ / ____
Dizziness____ / ____

EYES

Dry eyes ____ / ____
Poor vision ____ / ____
Blurred vision ____ / ____
Floaters in eye ____ / ____
Eye pain ____ / ____
Red eyes ____ / ____
Myopia ____ / ____
Hyperopia ____ / ____
Astigmatism ____ / ____
Flashes of light ____ / ____
Eye mucous____ / ____
Cataracts____ / ____
Glaucoma____ / ____
Eye surgery____ / ____

NOSE / THROAT / MOUTH

Jaw pops/clicks____ / ____
Grind teeth ____ / ____
Dental issues ____ / ____
Bad breath ____ / ____
Sore throat ____ / ____
Mucous in throat ____ / ____
Throat clearing ____ / ____
Frequent colds ____ / ____
Canker sores ____ / ____
Nose bleeds ____ / ____
Facial pain____ / ____
Swollen glands____ / ____
Sinus congestion____ / ____
Cold sores____ / ____

CARDIOVASCULAR

Hypotension ____ / ____
Fainting ____ / ____
Irregular heartbeat ____ / ____
Palpitations ____ / ____
Cold hands ____ / ____
Anemia ____ / ____

Hypertension ____ / ____
Chest pain ____ / ____
Angina ____ / ____

Heart attack ____ / ____
Heart murmur ____ / ____

High cholesterol____ / ____
Heart disease____ / ____
Heart surgery____ / ____

RESPIRATORY

Dry cough ____ / ____
Grey phlegm ____ / ____
Painful breath ____ / ____
Tuberculosis ____ / ____
Shortness of breath ____ / ____

Coughing blood ____ / ____
Yellow phlegm ____ / ____
Bronchitis ____ / ____
Pneumonia ____ / ____
Difficulty breathing____ / ____

Moist cough____ / ____
White phlegm____ / ____
Asthma____ / ____

URINARY

Pain urinating ____ / ____
Urgency ____ / ____
Incontinence ____ / ____

Frequency ____ / ____
Irregular ____ / ____

Blood in urine ____ / ____
Kidney disease ____ / ____
Bladder disease ____ / ____

Difficult to start ____ / ____
Difficult to stop ____ / ____

Kidney stones____ / ____
Decreased flow____ / ____
Kidney infections____ / ____
Bladder infections____ / ____

MUSCULOSKELETAL

Neck pain ____ / ____
Back pain ____ / ____
Achy ____ / ____

Muscle pain ____ / ____
Muscle weakness ____ / ____
Swollen joints ____ / ____

Stiffness____ / ____
Reduced range of motion____ / ____

FEMALE REPRODUCTIVE

Irregular cycle ____ / ____
Pain during intercourse ____ / ____
Unusual

Cramps ____ / ____
Discharge ____ / ____

Heavy bleeding____ / ____
Breast lumps____ / ____

bleeding ____ / ____ Hot flashes ____ / ____ Clotting____ / ____
Vaginal dryness____ / ____ PMS ____ / ____ Ovarian cysts____ / ____

21. Do you usually get up to urinate during the night? _ No _ Yes Number of times: _____
22. Is there a possibility you are pregnant? _ No _ Yes _ Maybe How many months: _____
23. Are you nursing? _ No _ Yes
24. Age at first menses: _____ Date of last pap smear: _____ Result: _____
25. Are you on birth control? _ No _ Yes Type: _____ Do you keep track of your cycle? _ No _ Yes
26. Number of pregnancies: ___ Miscarriages ___ Abortions ___ Ectopic ___ Multiple ___
Premature births ___ Living children ___
27. Onset of Menopause: _____ On HRT? _ No _ Yes Have you had a hysterectomy? _ No _ Yes
28. Describe your menstrual pattern: (if menopausal, describe pattern during menstruation)
Regularity: _ Irregular _ Variable _ Regular
Flow: _ Light _ Moderate _ Heavy _ Variable
Discomfort: _ Painless _ Moderate _ Painful
Length of cycle: ____ days (ex. 28 days)
Duration of flow: ____ days (ex. 3-5 days)

29. Describe any gynecological problems:

_____

_____

_____

_____

_____

_____

GENERAL

Osteoarthritis ____ / ____	Fevers ____ / ____	Diabetes____ / ____
Rheumatoid arthritis ____ / ____	Night sweats ____ / ____	Slow Metabolism____ / ____
Weight change____ / ____	Gallstone ____ / ____	Hypothyroid____ / ____
Cancer ____ / ____	Jaundice ____ / ____	Hyperthyroid____ / ____
Chemotherapy____ / ____	Prosthesis ____ / ____	
Epilepsy ____ / ____	Cosmetic surgery ____ / ____	Venereal disease____ / ____
Fatigue ____ / ____		Trauma____ / ____
Addictions ____ / ____		PTSD____ / ____

LIFESTYLE PATTERNS

30. Do you exercise regularly? _ No _ Yes Length of time: _____ Times per week:

_____

Types of exercise:

_____

31. How many 8 ounce cups per day of the following do you drink?

_ Plain Water _ Caffeinated Coffee _ Decaf Coffee _ Herbal Tea _ Caffeinated Tea _ Juice _ Soda _ Soy Milk _ Cow Milk _ Green Tea _ Carbonated Water _ Nut Milk _ Other:

_____

32. Do you have appropriate thirst? _ No _ Yes

Do you drink because you know you should? _ No _ Yes

33. Do you drink alcohol? _ No _ Yes

If yes, how often? _ Daily _ Several times weekly _ Several times monthly _ Seldom

I usually choose: _ Beer _ Red wine _ White wine _ Hard liquor

34. Do you currently smoke? _ No _ Yes

If yes, how many cigarettes per day? _____ How long have you smoked?

_____

If no, have you ever smoked? _ No _ Yes If yes, when did you quit?

_____

35. Do you currently or have you in the past use of addictive substances and recreational drugs? _ No _ Yes

Substance: _____ Amount: _____ If quit, when?

_____

Substance: _____ Amount: _____ If quit, when?

_____

36. Do you experience allergic reactions to any substances? Food, environmental, etc.

_____

_____

_____

_____

37. Were you allergic to any foods as a child? _ No _ Yes

If yes, what foods?

_____

Do you eat these foods now? _ No _ Yes

38. Do you use _ Deodorant _ Antiperspirant How often? _ Daily _ Sometimes _ Rarely

Type: _ Commercial _ Natural _ Deodorant stone _ Aluminum free _ Paraben free

39. Where do you buy your food most often?

_ Conventional Supermarket _ Orchard Nutrition Center _ Trader Joe's _ Farmer's Market

_ Other:

_____

40. Do you buy organic? _ No _ Yes _ Yes, when not too expensive _Half the time _ Rarely

41. On average, how many meals per week do you eat out? _____

Details (ex. lunches/when traveling):

_____

42. What type of restaurants do you choose? _ None _ Fast Food _ Chain _ Local _ Ethnic _ Take-out _ Other:

_____

43. Type of diet? Check all that apply: _ Red meat _ Poultry _ Fish _ Shellfish _ Eggs _ Dairy _Vegetarian _ Lacto-vegetarian _ Vegan _ Gluten free _ None _ Other:

_____

44. Do you eat leftovers? _ Never _ Rarely _ Sometimes _ Often _ Daily

If yes, how long are they in the refrigerator?

_____

DIETARY PATTERNS

Please be as detailed as possible and indicate your primary food choices and meal times:

Meal	Time	Typical food and beverage choices
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Late night		

45. Do you eat for emotional reasons? _ No _ Yes

If yes, what are your food choices?

_____

46. Do you graze? (Ex. munching continuously throughout the day) _ No _ Yes

If yes, what are your food choices?

_____

47. Do you have any routine around eating? (Ex. prayer, silence, deep breath, etc.) _ No _ Yes

Please explain:

_____

48. Do you have or have you had any food related issues or eating patterns? _ No _ Yes

Describe:

_____

49. Do you drink ice water/iced beverages with your meals? _ No _ Yes

DAILY SCHEDULE

Please describe your daily activities from the time you wake up until you go to sleep:

	Time	Activities
Arise		
Activities		
Breakfast		
Activities		
Lunch		
Activities		
Dinner		

Activities		
Bedtime		
Other:		

50. List other regular activities that are not included in the above schedule:

_____

_____

____

51. Other comments or concerns about daily routine:

_____

_____

____

52. Sleep and dreams

How many hours of sleep do you get in 24 hours:

_____

Do you sleep in on weekends? _ No _ Yes How many extra hours?

_____

Do you feel refreshed upon waking? _ Never _ Rarely _ Half the time _ Most days _ Always

Do you take naps? _ No _ Yes How often? _____ What time? _____ How long?

_____

Do you remember your dreams? _ No _ Yes

Do you have recurring dreams? _ No _ Yes

53. Personal safety

Do you live alone? _ No _ Yes

Do you have frequent falls? _ No _ Yes

Do you have vision or hearing loss? _ No _ Yes

54. Relationships

Do you find your work life stressful? _ No _ Yes

Do you find your work life satisfying? _ No _ Yes

Is your current intimate relationship stressful? _ No _ Yes

Is your current intimate relationship satisfying? _ No _ Yes

Are you currently experiencing stress in other personal relationships? _ No _ Yes

MENTAL AND EMOTIONAL PATTERNS

Check **one** box under each section, to the best of your ability:

Stress

- ❑ Under stress, I often become worried or overwhelmed
- ❑ Under stress, I often become irritable, but usually rise to the challenge
- ❑ Under stress, I often withdraw to observe and become reclusive

Decision making

- ❑ I often have difficulty making decisions, I am changeable
- ❑ I make decisions easily, but change my mind with new information
- ❑ I am easy-going about decisions, but careful

Projects

- ❑ I like to start projects, but at times have difficulty finishing them
- ❑ I like to start and finish projects, completion is important to me
- ❑ I like working on projects, but prefer to have others start them

Personality

- ❑ When I am balanced: I feel creative, enthusiastic and vivacious
- ❑ When I am balanced: I feel perceptive, disciplined and logical
- ❑ When I am balanced: I feel nurturing, calm and devotional

Social interactions

- ❑ Social butterfly, chatty
- ❑ The group leader, organizer
- ❑ Wall flower, supportive role in group

Approach to routine

- ❑ Difficult to follow routine
- ❑ Plans and organizes routine
- ❑ Follows routine methodically

Friends

- ❏ Few close friends, knows a lot of people
- ❏ Very selective, makes enemies easily
- ❏ Loyal with many friends

Money

- ❏ Spends impulsively, money is to be used
- ❏ Budgets spending, money is for achieving purpose
- ❏ Spends reluctantly, money is to be saved

MEDICATIONS - SUPPLEMENTS - HERBS

Please list all medications, supplements and herbs you are currently taking. Include significant remedies you have recently stopped taking, as well as birth control and hormone replacement therapy.

Type/Brand	OTC/ Prescription	Prescribed by	Taken for what purpose	How long	Dosage	Benefits

FAMILY MEDICAL HISTORY

Please list particular health problems of family members:

Mother:

_____
__

Father:

_____
__

Siblings:

_____
__

Other close blood relatives:

_____
__

FINANCIAL POLICY AGREEMENT

Financial Policy Agreement
for
North State Ayurveda

1. All in-office appointments are billed at $75 per 70 minutes. Any additional time will be billed at the same rate in 15 minute increments. Other services or products are billed separately.
2. The initial consultation will last 70 minutes, excluding time filling out packet.
3. The Report of Findings will be delivered to you approximately one week after initial consultation.
4. All other products and services, including massage and herbal formulas are charged at the time of receipt.
5. Fees are due at the time of services rendered.
6. Payment can be made by cash, check or credit and debit card.
7. Currently, North State Ayurveda does not bill insurance.
8. If you miss an appointment, you must adhere to a 24 hour cancellation policy to avoid cancellation charges.

I have read and understand the financial policies outlined above:

Signature:
_____Date:_____

Vata

element: air/ether

- ❏ Dry or rough skin
- ❏ Insomnia
- ❏ Constipation
- ❏ Fatigue
- ❏ Headaches
- ❏ Intolerance of cold
- ❏ Underweight or losing weight

- ❏ Anxiety, worry and restlessness
- ❏ Attention deficit with hyperactivity disorder

Pitta

element: fire

- ❏ Rashes
- ❏ Inflammatory skin conditions (including acne)
- ❏ Stomach aches
- ❏ Diarrhea
- ❏ Controlling and manipulative behavior
- ❏ Visual problems or burning in the eyes
- ❏ Excessive body heat
- ❏ Hostility, irritability
- ❏ Excessive competitive drive

Kapha

element: earth/water

- ❏ Oily skin
- ❏ Slow digestion
- ❏ Sinus congestion
- ❏ Nasal allergies
- ❏ Asthma
- ❏ Obesity
- ❏ Skin growths
- ❏ Possessiveness, neediness
- ❏ Apathy
- ❏ Depression
- ❏ Difficulty paying attention