Kerala Ayurveda Academy and Wellness Center
46500 Fremont Blvd, Suite 702 Fremont CA, 94538
Tel: 1-888-275-9103 Fax: 510-257-4378

Health History Questionnaire

Please take the time to fill out this questionnaire carefully so that I may provide you with a complete evaluation. All of your answers will be held absolutely confidential. If you have any questions, please ask.

Today's Date:		Age:	Gender: ❑ F ❑ M
Name (Last, First, MI):		Height:	Weight:
Address (No. Street):		**Date of Birth:**	Place of Birth:
City, State, Zip Code:		**Phone** (c) (h) (w)	
Social Security #: (opt'l)	**E-mail:**	Occupation:	❑ Married ❑Divorced/Separated ❑Single ❑Cohabitating
Emergency contact:	phone:	Referred by:	

Main problem(s) you would like help with:

When did the problem(s) begin? Please be specific:

To what extent do the problem(s) interfere with your daily activity (work, sleep, etc.)?

Have you been given a diagnosis for the problem(s)? If so, what was the diagnosis?

What kind(s) of treatment have you tried?

Please list any other current therapies:

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Past Medical History: (indicate by noting dates)

Cancer	_____	Hepatitis	_____	Heart Disease	_____
Seizures	_____	Diabetes	_____	Thyroid Disease	_____
	_____	AIDS/HIV	_____	Venereal Disease	_____
	_____	Rheumatic Fever	_____	High Blood Pressure	_____

Surgeries – type and date(s):

Significant Trauma (auto accidents, falls, etc.):

Significant Dental Work – type and date(s):

Your Birth History (prolonged labor, premature delivery, etc.):

Allergies (drugs, chemicals, foods):

Occupational Stress (chemical, physical, psychological):

Do you have a regular exercise program? Please describe.

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.):

Are you or have you ever been on a restricted diet? What kind?

Family Medical History: (please check M for maternal and/or P for paternal)

Cancer:	❑ M ❑ P	Asthma:	❑ M ❑ P	High Blood Pressure:	❑ M ❑ P
Diabetes:	❑ M ❑ P	Allergies:	❑ M ❑ P	Heart Disease:	❑ M ❑ P
Stroke:	❑ M ❑ P	Seizures:	❑ M ❑ P	Alcoholism:	❑ M ❑ P
Other (please specify): _____					❑ M ❑ P

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Please describe your average daily diet:

Morning	Afternoon	Evening	Snacks

Habits: (please indicate: None, Minimal, Moderate, or Heavy. Add comments where significant.)

	Heavy	Moderate	Light	None	Comments
Alcohol:	❑	❑	❑	❑	
Coffee:	❑	❑	❑	❑	
Tea:	❑	❑	❑	❑	
Tobacco:	❑	❑	❑	❑	
Exercise:	❑	❑	❑	❑	
Sleep:	❑	❑	❑	❑	
Appetite:	❑	❑	❑	❑	
Medication:	❑	❑	❑	❑	
Vitamins:	❑	❑	❑	❑	
Food Intake:	❑	❑	❑	❑	
Salt Intake:	❑	❑	❑	❑	
Stress Level:	❑	❑	❑	❑	

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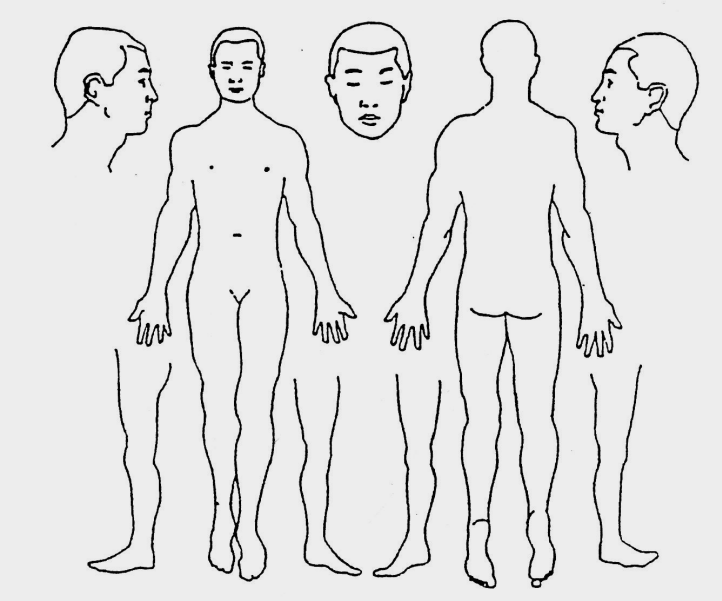
Indicate painful or distressed areas below:



Please indicate below any symptoms you have experienced in the last <u>three months</u>:

<u>General</u>

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

<u>Skin and Hair</u>

- ❑ Rashes
- ❑ Ulcerations
- ❑ Itching
- ❑ Hives
- ❑ Eczema
- ❑ Pimples
- ❑ Recent moles
- ❑ Change in skin/hair texture
- ❑ Dandruff
- ❑ Loss of hair
- ❑ Other skin/hair problems:_____
  _____

<u>Eyes, Ears, Nose, and Throat</u>

- ❑ Glasses
- ❑ Poor vision
- ❑ Cataracts
- ❑ Eye strain
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Color blindness
- ❑ Eye pain
- ❑ Spots in vision
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Ear aches
- ❑ Nose bleeds
- ❑ Sinus problems
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ Recurrent sore throats
- ❑ Sores on lips or tongue
- ❑ Jaw clicks

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Head

- ❑ Dizziness
- ❑ Facial pain
- ❑ Migraines
- ❑ Headaches
- ❑ Other head/neck problems: _____

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Dizziness
- ❑ Irregular heartbeat
- ❑ Chest pain
- ❑ Fainting
- ❑ Difficulty breathing
- ❑ Phlebitis
- ❑ Blood clots
- ❑ Cold hands
- ❑ Swelling of hands
- ❑ Cold feet
- ❑ Swelling of feet
- ❑ Other problems with heart or blood vessels: _____

Respiratory

- ❑ Cough
- ❑ Bronchitis
- ❑ Asthma
- ❑ Pneumonia
- ❑ Coughing blood
- ❑ Pain with deep breath
- ❑ Difficulty breathing 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
- ❑ Other: _____

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Belching
- ❑ Indigestion
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Abdominal pain / cramps
- ❑ Chronic laxative use
- ❑ Other problems with stomach or intestines: _____

Genito - Urinary

- ❑ Frequent urination
- ❑ Pain on urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Wake up to urinate how often:_____
- ❑ Kidney stones
- ❑ Impotency
- ❑ Sores on genitals
- ❑ Other: _____

Neuropsychological

- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Anxiety
- ❑ Easily susceptible to stress
- ❑ Seizures
- ❑ Concussion
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Depression
- ❑ Bad temper
- ❑ Areas of numbness
- ❑ Treated for emotional problems
- ❑ Other: _____
- ❑ Considered or attempted suicide

Pregnancy and Gynecology

- ❑ Painful periods
- ❑ Clots
- ❑ Unusual character (heavy or light)
- ❑ Irregular periods
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Breast lumps
- ❑ Pre-menstrual symptoms
- ❑ Use birth control
  Type:_____
  How long:
- # of pregnancies: _____
- # of births: _____
- # premature births: _____
- # miscarriages: _____
- # abortions: _____
- Age at first menses: _____
- Last menses start date: _____
- Menses duration: _____
- Length of full cycle: _____
- Date of last PAP: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: _____

We keep medical records of the health care services we provide for you. You may ask to see and copy your records. You may ask to correct your records. **Your records will be kept confidential unless you give us written permission to release them or we are required to do so by law.**

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of consultations, payment and health technique operations in this office. You may see your records or get more information about them by contacting our office.

For more information about our privacy practices please inquire with us.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Rogi or legal representative Date

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Name : _____ **Date:**_____

Welcome to Kerala Ayurveda Academy and Wellness Center. As you know, we are practitioners, faculties and interns of Ayurveda. We are not licensed physicians, nor are **Ayurveda** services licensed by the state. Ayurveda is the 5000 year old Wisdom of Healthy living. It is a way of natural healing and emphasizes on maintaining the harmony of Body-Mind-Spirit through diet, life style, and natural herbs. In Ayurveda the emphasis is not on a disease but on maintaining the balance of individual Body Constitution, so Ayurvedic treatments are never one size fits all, but they are custom tailored for each individual need. We are a primarily a training institution and the services our wellness center provide are for education purposes. As a training institution our practitioners, faculties and interns of Ayurveda, we will provide you with the followings kinds of services:

- Body - Constitutional analysis
- Diet and the life style counseling
- Ayurvedic body techniques
- Yoga and meditation Practices

Our method of treatment in Ayurveda is alternative or complementary to conventional medicine. If you ever have any concerns about the nature of your Ayurvedic services, please feel free to discuss them with us. We recommend that you inform your medical doctor that you are receiving **Ayurvedic** advises.

I have read and understood the above disclosure about the **Ayurvedic** services offered by Practitioners of Kerala Ayurveda Academy and Clinic. I have discussed with them, the nature of the services to be provided. I understand that the Practitioners, faculties and interns are not licensed physicians and that **Ayurvedic** services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself with a medical doctor.

_____ _____
Signature of Rogi Date

_____
Printed Name of Rogi

_____
Signature of Parent or Legal Guardian
(If Rogi is under 18yrs of age)

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Missed Appointment Policy

Please give us at least 48 hours cancellation notice for an initial appointment, and 24 hours notice for follow-up appointment. This allows us to call those waiting for an appointment to take your place.

If you do have health insurance that is accepted by our office, missed appointments are not billable to your insurance company. Unavoidable emergencies will be considered reasonable exceptions.

Please also be aware that the clinic allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

**NOTE:* *Cancellations for a Monday appointment must be made no later than 6:00pm the previous Friday.*

A fee of $50.00 will be charged for missed appointments without adequate notice.

I have read and agree to this missed appointment policy.

_____ _____
Signature of Rogi Date

_____
Printed Name of Rogi

_____
Signature of Parent or Legal Guardian
(If Patient is under 18yrs of age)