Health History Questionnaire

Name Street Address

City State

Zip code or Pin code Cell phone

Home phone

Email

Current Occupation

Do you have any allergies and if yes reactions for that?

❑ Seasonal

❑ Dust

❑ Pollen

❑ Foods (if so, which foods):____

❑ Animals

❑Any other

What brought you to Ayurveda, and what are your health and wellness expectations?

Do you have any current health concerns (physical/mental/emotional)?

Please mention all or prescribed medications, Vitamins, Supplements, Ayurveda medicines etc.

Preferably with Dose, Frequency and time of Consumption

Please indicate if there is a family history of the following:

- Heart Disease
- Diabetes
- Bronchial Asthma
- High Blood Pressure
- Stroke
- Cancer
- Mental Illness

Other _

Daily Routine

Do you get up early?

❑ Yes ❑ No

At what time?

Do you go to bed early?

❑ Yes

❑ No

At what time?

Do you sleep during the day? What time?

❑ Yes

❑ No

At what time?

How do you generally feel when you wake up in the morning?

❑ Fresh and well rested

❑ A little sleepy

❑ Sluggish and groggy

How would you describe your experience of sleep?

❑ Sound; Normal duration

❏ Light, interrupted

❏ Not enough

❏ Too heavy and/or long

❏ Difficulty falling asleep

❏ Difficulty waking up

❏ Awaken too early

❏ Frequent nightmares

How regularly do follow your ideal routine (i.e., go to bed early, eat meals on time, exercise regularly)?

❏ Very regularly

❏ Some what regularly

❏ Irregularly

Describe your bowel movements.

❏ Once every 2–3 days

❏ Once daily

❏ 2–3 times per day

❏ First thing in the morning

❏ Late in daytime

❏ Immediately after meals

❏ Immediately after dinner

❏ Need laxative daily

❏ Other (please specify)

Bowel nature:

❏ Soft

❏ Medium

❏ Hard

Bowel movement associated with:

❏ Pain

❏ Blood

❏ Mucous

❏ Foul smell

❏ Other

How is your Urination?

❏Too frequent

❏Many times at night

❏Burning while passing urine

❏Dark yellow in color

Do you travel often?

❏ Yes

❏ No

How often do you exercise?

❏ Daily

❏ Weekly

❏ Not at all

What type of exercise do you do and what is the duration?

Diet

Are you following any specific diet by recommendation from any Doctor or Health care practitioner or by our own? If yes please give the details of the same.

Foods	Daily	weekly	Monthly	Never
Grains				
Fruits				
Veggies				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
(beef/pork)				
Sweets				
Other				

What do you eat generally for?

Breakfast---------------

Lunch--------------------

Dinner--------------------

Do you eat between meals?

❑ Yes (if so, what kinds of snacks)____

❑ No

Do you eat at regular times?

❑ Yes

❑ No

Which is your biggest meal?

❑ Breakfast

❑ Lunch

❑ Dinner

How would you rate your digestion?

❑ Good

❑ Fair

❑ Bad

How much water do you drink daily?

How would you rate your caffeine intake?

❑ None

❑ Occasionally

❑ All day every day

How often do you drink alcohol?

❑ Never

❑ Weekends/Socially

❑ 3 days/week

❑ Every day

Do you experience any of the following?

❑ Anxiety

❑ Depression

❑ Panic Attacks

❑ High Stress

❑ Worry

❑ Anger

Only for women:

Is your menstrual cycle regular? Please mention the duration of cycle

❑ Yes

❑ No, ?

How is your menstrual flow?

❏ Normal

❏ Light

❏ Heavy

❏ Absent

❏ Menopause

Do you have any symptoms before or during menstruation?

❏ None

❏ Pain

❏ Acne

❏ Bloating

❏ Migraines

❏ Depression

❏ Irritation

❏ Clots

Do you use any form of birth control?

❏ Yes (list kind)

❏ No

Please indicate any other information you'd like to share