

AYURVEDA AND INDIAN SYSTEMS OF HEALING



CONFIDENTIAL CLIENT HEALTH HISTORY

Please provide us with information regarding your state of health so that it is safe for you to receive specific treatments. Should your health status change please let us know. Information is kept confidential in regards to your treatment except as required by law or except to facilitate diagnosis, assessment or treatment. No information will be released without your written consent. Please bear in mind that 24 hours is required for cancellation and a \$30 dollar NSF charge may apply on all cheques returned. Full fee on missed appointments through credit on file.

DATE: _____

PART 1: (complete all)

NAME: _____ DATE: _____ FOUND US BY: _____
 ADDRESS: _____ CITY: _____ PROV: _____ P. CODE: _____
 TEL RES: _____ WORK: _____ CEL: _____ EMAIL: _____
 DATE OF BIRTH: _____ WEIGHT: _____ HEIGHT: _____ OCCUPATION: _____
 PAYMENT: Visa MC AMEX Debit Cash Cheque
 CREDIT CARD INFORMATION: Number: _____ Exp: _____

What is the primary reason for your visit with us today?

Your Doctor's Name: _____ Phone #: _____
 Location: _____

PART II: Please mark ailments/complaints that you are experiencing and/or have experienced.

How has your health been? _____

RESPIRATORY INFECTIONS

- Shortness of breath
- Bronchitis
- Asthma
- Bronchial Allergy
- Chronic Cough
- Emphysema

CARDIOVASCULAR

- High Blood Pressure
- Low blood pressure
- Hemoglobin _____
- RBC _____ WBC _____
- ESR _____
- High Cholesterol
- Heart Condition
- CCHF (heart failure)
- Heart Attack
- Phlebitis
- Stroke
- Body Temperature _____

- Pace maker
- Poor Circulation

HEAD / NECK

- Vision Problems or Loss
- Ear Problems
- Hearing Problems / Loss

HEADACHES

- Migraines
- Cluster Tension
- Concussion – Date: _____

INFECTIONS

- Hepatitis TB HIV
- Scarlet Fever Chicken Pox
- Glandular Fever
- Other _____

SKIN

- Eczema _____
- Rashes _____
(describe)
- Psoriasis Varicose Veins
- Bruise Easily Surgery

ALLERGIES

List: _____

Allergies causing Anaphylaxis or Irritation

OTHER CONDITIONS

- Arthritis Anxiety
- Fatigue
- Thyroid: Hypo Hyper

Thyroid Surgery? _____

Loss of sensation _____

Diabetes (onset) _____

INJURIES

- Fracture What?: _____
- Dislocation What?: _____
- Sprain What?: _____
- Ligament Tear What?: _____
 - Partial Full
- Organ Injury What?: _____

SOFT TISSUE / JOINT DISCOMFORT

Its' nature: _____

- Neck Shoulders: R L
- Arms Wrist
- Hands Feet
- Upper Back Mid/Low Back
- Legs Knees
- Other

OTHER HEALTH MODALITIES?

- Chiropractor
- Massage Therapy
- Regular exercises

- Physiotherapy
- Other

WOMEN Only

Pregnant (due date) _____

Gynecological conditions:

Describe: _____

DO YOU SMOKE? YES NO

PART III: Current Medications

Please List:

Surgery: _____ DATE(S): _____

Injury: _____ DATE: _____

Special Note: (presence of internal pins, wires, artificial joints, special equipment – cane, wheelchair, etc.)

Part IV: Volunteer for Case Study Participation

If you would be interested to participate in our Case Study Program, please sign below to express only your general interest. This is not an agreement, but it shows your willingness to proceed with a study of how Ayurveda can benefit your health/condition/disease, as the case may be.

Possible outcomes could include educating the public through published medical articles, book,