Rupa Ayurveda- Josh Whiteley, CAP, L.Ac.

Patient Intake Profile

General Information

Date: ____/____/_____

Patient name: _____ Preferred name:_____

Address:_____ City, State, Zip:_____
Phone Number:_____ email:_____ Age:____ Date of birth:__/__/___
Time and location of birth:_____, _____ Occupation:_____
Relationship status:_____ Gender and pronoun preference:_____
Do you have a primary care provider? Name:_____ Phone number:_____
Emergency contact person:_____ Phone number:_____
Their relationship to you:_____
How did you hear about the clinic?_____

Would you like to receive our E-newsletter? *(typically once every 4-6 weeks)* *Yes* ☐ *No* ☐

What are your primary health concerns and goals for seeking out an Ayurvedic consultation?
1._____
2._____
3._____

What makes you feel better?_____
What makes you feel worse?_____
How long have these issues bothered you?_____

Medical History

Please list any medical conditions you have had or are dealing with.

Serious illnesses:_____
_____

Surgeries:_____
_____

Family History of serious conditions if known:_____
_____
_____

Known allergies:_____
_____

Supplements you take regularly:_____
_____

Medications:_____
_____

General Habits

Do you consume alcohol? If so, how frequently? _____
Do you consume tobacco? If so, how frequently?_____
Do you consume recreational drugs? If so, how frequently?_____

Would you like help with cutting back on any addictive habits? Yes ☐ No ☐

How many cups of caffeinated beverages do you consume each day? _____
Caffeinated beverages regularly consumed._____

How many cups of non-caffeinated beverages each day?_____
Non- caffeinated beverages regularly consumed._____

How many glasses of water do you consume each day?_____

Do you exercise regularly? Yes ☐ No ☐
What type of exercise and how frequently?_____

Any other regular practices?_____

Have you, or are you following any specific diet? Please describe the diet, objectives, length of time, and results:
_____
_____
_____

Any specific food cravings? Sweets ☐ Salty ☐ Sour ☐ Meat ☐ Dairy ☐ Other_____

Describe your typical sense of body temperature, how you generally feel most of the time. Do you tend to run more warm or cold?_____

How is your digestion and bowel movements, typically? Do you tend towards good digestion, irregular, not good, constipation, loose stools,etc.?_____
_____

How is your appetite generally? Weak ☐ Normal ☐ Strong ☐ Variable ☐ Constant ☐

Do you tend to snack between meals? If so how frequently?_____

How is your energy level typically after eating? Lower ☐ Higher ☐ Same ☐

Do you regularly need naps? Yes ☐ No ☐

Daily Routine

List typical activities that occur on a regular basis.

	TIME	ACTIVITIES
Morning		
Wake		
Meals		
Activity		
Mid day		
Meals		
Activity		
Evening		
Meals		
Activity		

Additional Notes:_____
_____
_____

What time do you typically go to sleep?_____
Is it easy to fall asleep?_____ Easy to stay asleep?_____

Any sleep time habits or other sleep issues?_____
_____

Eating Habits

Describe the typical meals you eat

Time	Meal	Foods & Beverages
___:____	Breakfast	
___:____	Lunch	
___:____	Dinner	

Snacks typically consumed:_____
_____

Symptoms

Check all that you have experienced in the last six months.

Allergies	Breathlessness ☐	Congestion ☐	Irritation ☐	Hives ☐
	Inflammation ☐	Watery eyes ☐	Rashes ☐	Itchy eyes ☐
	Tight chest ☐	Wheezing ☐	Drippy nose ☐	Other _____
Perspiration	Rarely sweat ☐	Excessive ☐	Cold or clammy sweat ☐	
		With body odor ☐		
Musculoskeletal	Weakness ☐	Growths/tumors ☐	Soreness ☐	Twitching ☐
	Spasms ☐	Bruise easily ☐	Cysts ☐	Pain ☐
	Cramping ☐	Numbness ☐	Tingling	Other_____
	Scoliosis ☐	Arthritis ☐	Osteopenia ☐	Sclerotic changes ☐
	Pain in joints ☐	Bone Spurs ☐	Cracking ☐	Osteoporosis ☐
	Bursitis ☐	Bone Tumors ☐	Stiffness ☐	Popping/clicking joints ☐
	Disc issues ☐			Other_____
Circulation	Cold extremities (hands & feet) ☐	Warm extremities (hands & feet) ☐		Clammy feeling ☐
	Bruise easily ☐	Varicose Veins ☐		Other_____

Body weight	Variable	Stable	Thin/slender
	Hard to gain weight	Can easily gain weight	Other_____
Gastrointestinal	Colitis	Crohn's	Irritable Bowel Syndrome
	GERD(reflux)	Diarrhea	Diverticulitis/diverticulosis
	Constipation	Ulcers	Celiac Disease
	Vomiting	Undigested stool	Abdominal Pain
	Belching	Gas/bloating	Nausea
	Blood in stool	Hemorrhoids	Other_____
Reproductive & Urinary	Gout	UTIs	Yeast infections
	Kidney stones	Blood in urine	Fibrocystic ovaries
	Frequent urination	Amenorrhea	Low libido
	Urine discoloration	Sexual dysfunction	Other_____

What are the major stressors in your life?

_____

_____

Endocrine, Cardiovascular or Autoimmune Conditions?

_____

_____

_____

General Symptoms								
	Headaches	☐	Swollen glands	☐	Ear discharge	☐	Ear ringing	☐
	Migraines	☐	Foggy headedness	☐	Fainting	☐	Hearing loss	☐
	Vertigo	☐	Eye pain	☐	Dizziness	☐	Lack of clarity	☐
	Thinning hair	☐	Red eyes	☐	Bad breath	☐	Memory loss	☐
	Dry eyes	☐	Burning eyes	☐	Heart palpitations	☐	Tongue pain	☐
	TMJ	☐	Blurry vision	☐	Shortness of breath	☐	Chronic cough	☐
	Dry skin	☐	Skin rashes	☐	Acne	☐	Hot flashes	☐

Other_____

Mental/Emotional								
	Fatigue	☐	Grief	☐	Anger	☐	Repetitive thoughts	☐
	ADD/ADHD	☐	Fear	☐	Anxiety	☐	Loneliness	☐
	Depression	☐	Stress	☐	Worry	☐	Irritability	☐
	Lethargy	☐	Overwhelmed	☐	Self destructive	☐	Insomnia	☐

Other_____

Additional Notes *Is there anything else you would like to add or would like help with?*

_____

_____

_____

_____

_____

_____

We will go over your health history and discuss issues more in depth where needed. The goal of Ayurveda is to help your body to find its most optimal state for health and healing and to make adjustments to further your progress. Ayurveda has been practiced for 5,000 years and through its time tested practices and principles, we will formulate a plan that is specific to your needs and abilities using Ayurvedic diagnosis and determination of your personal constitution and imbalances. Resources will also be made available to help you understand these concepts. Ayurveda is a practice, one should view this consultation as a starting point and an ongoing process to best utilize these resources. Your individualized consultation may include diet and lifestyle recommendations, herbal and oil therapy, yoga and breathing techniques, Vastu and Jyotish recommendations, and other Chinese medicine or complimentary modalities as seen fit by your practitioner. Follow up visits are recommended as well to reassess and adjust when needed. These tools will help to empower you to use this great medicine to its full potential for a lifetime. I look forward to meeting you.

Ayurvedic Treatment- Informed Consent

I hereby request and consent to treatment by Josh Whiteley, CAP, L.Ac. and/or other practitioners who now or in the future treat me while employed by, or serving as a back up for Josh Whiteley. Ayurveda and Chinese medicine are centuries old and the longest continuously practiced healthcare systems in the world. The advice and treatment given by an Ayurvedic practitioner is based on conceptual understandings of your unique constitution and any imbalances. Your consultation and/or treatment may include dietary advice, herbal treatment, yoga, breathing exercises, acupuncture, and related Chinese medicine modalities. Your practitioner will educate and inform you on any modalities utilized in treatment, answer any questions, and will only perform these modalities with your given consent. Ayurveda and Chinese medicine are recognized by the National Center for Complimentary and Alternative Medicine (NCCAM), an office of the National Institute for Health (NIH), as forms of complimentary and Alternative Medicine in the United States. Practitioners of acupuncture and Oriental medicine are required by state and federal law to be licensed to practice and all relevant legal forms are available for viewing at your request. Your practitioner is not a medical doctor, nor is the center a medical facility. Any recommendations or information conveyed by your practitioner is not a substitute for professional advice from an Allopathic physician. We highly encourage you to remain under the care and counsel of a primary care provider at all times. We also do not recommend that you alter the taking of any medications you have been prescribed by your primary care provider without their direct and authorized consent. Your practitioner does not diagnose or treat pathological conditions, but uses complimentary modalities to affect the functioning of your body.

I understand that these forms of treatments are generally very safe and non invasive, but that some side effects, though very rare, may occur with acupuncture. These include but are not limited to bruising, numbness or tingling near the acupuncture site that may last a few days, dizziness, and fainting. Single use and sterile needles are used at all times. Some rare side effects occurring with the ingestion of herbs and supplements may include but are not limited to nausea, gas, stomachache, vomiting, headache, diarrhea, and rashes. I agree to notify my practitioner immediately if any symptoms arise. I will also notify my practitioner if I become or are already pregnant as some forms of treatment may be contraindicated thereafter.

I do not expect my practitioner to be able to anticipate all possible risks and complications of treatment and will rely on their expertise to exercise good judgement during the course of treatment to determine what is in my best interest with the facts known at the time. I also understand that results can not be guaranteed.

I understand that my practitioner and office staff will have access to and may review my patient records and lab reports, but all my records will be kept confidential and in compliance with HIPPA standards. My records will not be released with out my written consent.

By voluntarily signing below, I show that I have read the above consent to treatment, have been notified of the risks and benefits of Ayurvedic medicine, acupuncture, related modalities used, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name:_____

Patient Signature:_____ Date____/____/_____
(or Patient Representative)