



**(PLEASE WRITE NEATLY IN BLACK INK ONLY)**

Appointment Date & Time: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone—Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-mail: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Marital/partner status: \_\_\_\_\_ # of children: \_\_\_\_\_ Ages: \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear about *Niroga Ayurveda*? \_\_\_\_\_

Please tell us why you have chosen to have an Ayurvedic Consultation: \_\_\_\_\_

\_\_\_\_\_

**FINANCIAL POLICY AGREEMENT**

1. The 1-week cleanse package is a total of **\$315**. The package includes:
  - Two 1-hour consultations (before and after your cleanse experience)
  - One 60-minute traditional Ayurvedic oil massage
  - Recipes and ingredients (excepting fresh vegetables) for a cleansing diet
  - Custom oil for self – massage (4 oz.)
  - Detoxifying tea
  - Natural and safe purgation supplies based on Ayurvedic principles
  - Herbal formulations to aid digestion and cleansing
2. Payment for the cleanse package must be made by cash or check, payable to Vidya Venkatesh, on or before the first consultation. *Niroga Ayurveda* does not provide monthly billing services.
3. *Niroga Ayurveda* does not bill insurance companies for services or herbs.
4. If you miss an appointment without giving 24 hours notice, a \$25.00 fee is charged.
5. Your customized program incorporates herbal formulas. Herbs for the 1-week cleanse are included in the package. Any additional herbs that you desire will be billed separately. Pricing varies based on the contents. Additional shipping charges may apply.
6. If additional services are recommended, payment for those services must be made when services are rendered.

*I have read and understood the financial policies of the Niroga Ayurveda.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**(1) FOOD CHOICES**

What types of foods do you eat on a regular basis?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

**(2) DAILY LIQUID INTAKE** *(Indicate number of 8 ounce cups per day)*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Caffeinated Coffee/Tea _____   | <input type="checkbox"/> Herbal Tea or Juice _____ | <input type="checkbox"/> Plain water _____        |
| <input type="checkbox"/> Decaffeinated Coffee/Tea _____ | <input type="checkbox"/> Soda or soda pop _____    | <input type="checkbox"/> Cow or Goat Milk _____   |
|   |  | <input type="checkbox"/> Grain/nut/soy milk _____ |

**(3) HABITUAL EATING PATTERNS**

Describe any current or past eating patterns or any other food related issues.

**(4) DAILY SCHEDULE** *(include approximate times)*

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

		TIME	HABITUAL ACTIVITIES	PRACTITIONER NOTES
MORNING	Awaken			
	Mealtime			
	Activities			
DAY	Mealtime			
	Activities			
NIGHT	Mealtime			
	Activities			
	Bed-time			

**(5) ALLERGIES OR SENSITIVITIES**

Do you have allergic reactions to any substances (including food, pollens, medicines)? If yes, please list.



**(6) CHALLENGING PATTERNS**

Please indicate any physical and emotional patterns that *you find challenging* by assigning a **Frequency** (a number from 1 to 3) and **Intensity** (a number from 1 to 10):

<b>FREQUENCY</b> 1 = DAILY 2 = SEVERAL TIMES WEEKLY 3 = SEVERAL TIMES MONTHLY	<b>INTENSITY</b> 1 TO 3 = MILD DISCOMFORT 4 TO 6 = MODERATE DISCOMFORT 7 TO 10 = SEVERE DISCOMFORT
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**C. EMOTIONS**

	Frequency 1-3	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

**A. DIGESTION**

	Frequency 1-3	Intensity 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

**B. ELIMINATION**

	Frequency 1-3	Intensity 1-10
Constipation (less than 1 BM/day)		
Alternating constipation & diarrhea		
Food particles in stool		
Diarrhea		
Rectal pain or hemorrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

**(7) ADDITIONAL SYMPTOMS OF CONCERN**

	Frequency 1-3	Intensity 1-10

**(8) PREVIOUSLY DIAGNOSED CURRENT CONDITIONS**

	PRACTITIONER NOTES <i>Please describe symptoms of diagnosed condition</i>



**(9) AYURVEDIC HISTORY**

For each category, please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to your practitioner about a given category, please place a check (✓) in the column on the right. For each category, please indicate whether your tendency is a long term condition or not.

CATEGORY				LONG TERM	✓	PRACTITIONER NOTES
Appetite	<input type="checkbox"/> My hunger level is variable and I often forget to eat.	<input type="checkbox"/> I have a strong appetite and don't like to miss meals.	<input type="checkbox"/> I like to eat, but I can go without eating with no discomfort.	Y	N	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>			
Appetite	<input type="checkbox"/> If I miss a meal, I often get light-headed, anxious, or cranky.	<input type="checkbox"/> If I miss a meal, I often get irritable or angry.	<input type="checkbox"/> If I miss a meal, it doesn't really bother me.	Y	N	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>			
Digestion	<input type="checkbox"/> After eating, I often experience gas or bloating.	<input type="checkbox"/> After eating, I often experience heartburn or acidity.	<input type="checkbox"/> After eating, I often feel heavy or sleepy.	Y	N	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>			
Elimination	<input type="checkbox"/> I tend to have irregular bowel movements one time per day or less.	<input type="checkbox"/> I tend to have 1 to 2 bowel movements daily, usually with regularity and ease.	<input type="checkbox"/> I tend to have one bowel movement per day with no straining or difficulty.	Y	N	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>			
Elimination	<input type="checkbox"/> My bowel movements are often dry and hard. At times, I may strain and push.	<input type="checkbox"/> My bowel movements are usually well-formed, but sometimes they are loose and may burn.	<input type="checkbox"/> My bowel movements are usually well-formed, slow, and easy.	Y	N	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>			
Weight	<input type="checkbox"/> I usually don't gain weight very easily.	<input type="checkbox"/> When I gain weight, it is easy to lose it.	<input type="checkbox"/> I gain weight easily and lose it slowly.	Y	N	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>			
Body Temperature	<input type="checkbox"/> My hands and feet often feel cold, and I prefer warmer climates.	<input type="checkbox"/> I am warm most of the time, no matter what the climate is.	<input type="checkbox"/> I adapt easily to most conditions, but tend to feel cool.	Y	N	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>			



Skin	<input type="checkbox"/> My skin tends to be dry. When very dry, it tends to feel rough. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> My skin tends to flush easily and has a reddish or yellowish shade. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> My skin is thick, smooth, and often tends to feel damp or oily. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N
	<input type="checkbox"/> When I have rashes, they tend to be dry and itchy. Blemishes are usually blackheads. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> When I have rashes, they tend to be red and burning. Blemishes are usually acne. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> When I have rashes, they tend to be wet and oozing. Blemishes are usually white pimples. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	
Sleep	<input type="checkbox"/> I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> I tend to sleep soundly and awaken with ease. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	

**MENTAL & EMOTIONAL PATTERNS**

Stress	<input type="checkbox"/> Under stress, I often become worried and overwhelmed. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> Under stress, I often become irritable but usually rise to the challenge. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> Under stress, I often withdraw to observe or become reclusive. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N
	<input type="checkbox"/> I am changeable and often have difficulty making decisions. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> I make decisions easily, but can change my mind with new information. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> I am careful, but easy-going about decisions. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	
Projects	<input type="checkbox"/> I like to start projects, but at times have difficulty finishing them. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> I like to start and finish projects. Completion is important to me. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> I like working on a project, but prefer to let others start them. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N
	<input type="checkbox"/> When I am balanced, I feel creative, enthusiastic, and vivacious. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> When I am balanced, I feel perceptive, disciplined, and logical. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> When I am balanced, I feel nurturing, calm, and devotional. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	

**FOR PRACTITIONER USE ONLY:**

V PRAKRUTI:	P PRAKRUTI:	K PRAKRUTI:
V VIKRUTI:	P VIKRUTI:	K VIKRUTI:



**FOR WOMEN ONLY**

LONG TERM	✓	PRACTITIONER NOTES
<p>Is there a possibility that you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possible</p> <p>Are you menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last period _____</p> <p><i>If menopausal, please answer below according to your past menstrual patterns.</i></p> <p>Practitioner use only V <input type="checkbox"/> P <input type="checkbox"/></p> <p><input type="checkbox"/> My menstrual cycle is irregular. It comes every ___ to ___ days and lasts ___ days.</p> <p>Practitioner use only V <input type="checkbox"/> P <input type="checkbox"/></p> <p><input type="checkbox"/> My menstrual flow is often light, but may vary.</p> <p>Practitioner use only V <input type="checkbox"/> P <input type="checkbox"/></p> <p><input type="checkbox"/> I often have severe, cramping pain during menses.</p> <p>Practitioner use only V <input type="checkbox"/> P <input type="checkbox"/></p>	<p>I experience PMS: <input type="checkbox"/> often <input type="checkbox"/> sometimes <input type="checkbox"/> not at all</p> <p><input type="checkbox"/> cramps <input type="checkbox"/> bloating <input type="checkbox"/> headache <input type="checkbox"/> weight gain <input type="checkbox"/> irritable <input type="checkbox"/> breast tenderness</p> <p>Practitioner use only V <input type="checkbox"/> P <input type="checkbox"/></p> <p><input type="checkbox"/> My menstrual flow is heavy and is very consistent.</p> <p>Practitioner use only V <input type="checkbox"/> P <input type="checkbox"/></p> <p><input type="checkbox"/> I rarely have pain during menses.</p> <p>Practitioner use only V <input type="checkbox"/> P <input type="checkbox"/></p>	<p>Y N</p> <p>Y N</p> <p>Y N</p>

**FOR PRACTITIONER USE ONLY:**

V PRAKRUTI:	P PRAKRUTI:	K PRAKRUTI:
V VIKRUTI:	P VIKRUTI:	K VIKRUTI:

**NOTES:**



**(10) CURRENT MEDICATIONS, HERBS, OR SUPPLEMENTS**

*What medications, herbs, and supplements are you currently taking? Please include significant remedies that you have stopped taking, including birth control, and hormone replacement therapies.*

Substance	Over-the-Counter (OTC)/ Prescription (Rx)?	Herb/Drug/ Vitamin?	Prescribed by? (Self, MD, Other)	For what purpose?	For how long?	What dosage?	What have the benefits been?