



**(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. Consultations are billed at the rate of **\$95 per hour**. Discounted rates are available if you purchase one of the following package deals:
  - **Disease Management Silver Package (4 hours of consultation): \$370:** Includes a 2-hour Initial Consultation, a 1-hour Report of Findings meeting and one 1-hour follow up visit.
  - **Disease Management Gold Package (7 hours of consultation): \$630:** Includes 3 additional 1-hour consultations in addition to what is offered in the silver package.
2. Your customized program often incorporates herbal formulas. Pricing varies based on the contents of your personalized herbal formulas and will be explained to you at the time that they are recommended to you. Additional shipping charges may apply.
3. Payment for herbs and consultations must be made by cash or check, payable to Vidya Venkatesh, at the time that services are rendered. *Niroga Ayurveda* does not provide monthly billing services.
4. *Niroga Ayurveda* does not bill insurance companies for services or herbs.
5. If Pancha Karma services are recommended, payment for those services is made when services are rendered.
6. If you miss an appointment without giving 24 hours notice, a \$25.00 fee is charged.

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

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



## **INFORMED CONSENT**

*to authorize Complementary or Alternative Health Care through*

### **NIROGA AYURVEDA**

***All Patients who participate in Ayurvedic health care through this program  
should be advised of the following information:***

1. The Niroga Ayurveda is not a Medical Facility.
2. Vidya Venkatesh, the director of Niroga Ayurveda, is a Clinical Ayurvedic Specialist (CAS) and Pancha Karma Specialist (PKS). She is not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care. She received her training at the following institutions: California College of Ayurveda, Grass Valley, California; Arya Vaidya Pharmacy, Coimbatore, India; and Ayurvedic Institute, Albuquerque, New Mexico.
3. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003.
4. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If your practitioner refers you to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
5. No one in association with the Niroga Ayurveda may recommend altering your prescriptions without the approval of your medical doctor. Your practitioner may suggest that you speak to your doctor about reducing medication when he/she feels that it is appropriate.
6. While your practitioner may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, the findings will be evaluated from an Ayurvedic perspective only and not from a Western medical perspective. **This examination does not take the place of a medical evaluation.** If, as a result of the examination any findings suggestive of a possible medical imbalance is found, your practitioner will refer you to a Medical Doctor for further evaluation.
7. Ayurveda is a complimentary and alternative health care system. Care from your practitioner may be utilized as a compliment to your current health care program.

*I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with Niroga Ayurveda.*

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



**CONFIDENTIAL PATIENT HISTORY**  
**NIROGA AYURVEDA**  
**HEALTHCARE CENTER**

**WHAT YOU CAN EXPECT FROM YOUR VISIT**

Ayurveda is a natural healing system that has been successfully practiced for thousands of years. Originating in ancient India, this medical tradition states that each person's path toward optimal health is unique--because each person is unique. The healing programs offered at Niroga Ayurveda are based on effective, time-honored principles which focus on understanding your particular body-mind constitution and the unique nature of your imbalance.

Each individualized program is formulated may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other natural therapeutics. In order to successfully implement these Ayurvedic principles into your life, frequent regular follow-up visits with your practitioner are recommended over a six- to twelve-month period.

The goal of all Ayurvedic programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.

**Patient's Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_

**(1) PAST MEDICAL HISTORY**

*Include major conditions **and** dates of treatment and procedures performed.*

a. Serious illnesses: \_\_\_\_\_  
\_\_\_\_\_

b. Hospitalizations: \_\_\_\_\_

c. Operations: \_\_\_\_\_

d. List other pertinent past conditions: \_\_\_\_\_  
\_\_\_\_\_

e. Have you been under the care of a licensed health care professional in the past year?  Yes  No

If so, for what reasons: \_\_\_\_\_

f. Have you had any cosmetic surgery or procedures performed?  Yes  No

If so, please list with dates:  
\_\_\_\_\_  
\_\_\_\_\_



**(2) FAMILY HISTORY**

Indicate what members of your immediate family have had these conditions. (Go back one generation)

(If adopted, answer according to family heritage, if known.)

- High Blood Pressure \_\_\_\_\_  Heart Disease \_\_\_\_\_  Other \_\_\_\_\_
- Cancer \_\_\_\_\_  Mental Disorder \_\_\_\_\_
- Stroke \_\_\_\_\_  Diabetes \_\_\_\_\_

**(3) ALCOHOL, TOBACCO AND SUBSTANCE USE**

**PRACTITIONER NOTES:**

<p>a. Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, how often: <input type="checkbox"/> Daily <input type="checkbox"/> Several times weekly <input type="checkbox"/> Several times monthly <input type="checkbox"/> Seldom                  I usually choose: <input type="checkbox"/> beer <input type="checkbox"/> wine <input type="checkbox"/> sweet or hard liquor</p>	
<p>b. Have you ever smoked tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much per day? _____                  If you have quit smoking, when did you quit? _____</p>	
<p>c. Any current or past use of addictive or habitual substances? <input type="checkbox"/> Yes <input type="checkbox"/> No (Note: This will be kept confidential) Please list all substances (either current or long-term past usage): _____                  _____</p>	

**(4) REGULAR PRACTICES**

<input type="checkbox"/> EXERCISE/HATHA YOGA (Specify)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> TEAM SPORTS/RECREATION (Specify)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> TRAVEL (Include commute if applicable)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> SPIRITUAL PRACTICES (Specify)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> MEDITATION/PRAYER/PRANAYAMA (Specify)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> OTHER (Include creative activities)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month

**(5) SEXUAL ACTIVITY**

According to Ayurveda, a person's level of sexual activity impacts health and well-being in the same way as other aspects of daily life--such as diet or sleep.

a. How often do you engage in sexual activity (include sex with partner and masturbation):

- Daily  Several times per week  Several times per month  Occasionally  Not at all

b. Is your current sexual activity satisfactory?  Yes  No



**(6) FOOD CHOICES**

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

BREAKFAST:

---

LUNCH:

---

DINNER:

---

SNACKS:

---

**(7) 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 _____ |

**(8) HABITUAL EATING PATTERNS**

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

---

**(9) 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			

**(10) ALLERGIES OR SENSITIVITIES**

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



**(11) 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
--	---

**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		

**(12) ADDITIONAL SYMPTOMS OF CONCERN**

	Frequency 1-3	Intensity 1-10

**(13) PREVIOUSLY DIAGNOSED CURRENT CONDITIONS**

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



**(14) 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. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N	<input type="checkbox"/> I like to eat, but I can go without eating with no discomfort. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<input type="checkbox"/> If I miss a meal, I often get light-headed, anxious, or cranky. <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. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N	<input type="checkbox"/> If I miss a meal, it doesn't really bother me. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<input type="checkbox"/> After eating, I often experience gas or bloating. <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. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N	<input type="checkbox"/> After eating, I often feel heavy or sleepy. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<input type="checkbox"/> I tend to have irregular bowel movements one time per day or less. <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. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N	<input type="checkbox"/> I tend to have one bowel movement per day with no straining or difficulty. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<input type="checkbox"/> My bowel movements are often dry and hard. At times, I may strain and push. <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. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N	<input type="checkbox"/> My bowel movements are usually well-formed, slow, and easy. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<input type="checkbox"/> I usually don't gain weight very easily. <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. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N	<input type="checkbox"/> I gain weight easily and lose it slowly. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<input type="checkbox"/> My hands and feet often feel cold, and I prefer warmer climates. <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. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Y N	<input type="checkbox"/> I adapt easily to most conditions, but tend to feel cool. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
	<input type="checkbox"/> I am warm most of the time, no matter what the climate is. <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.	<input type="checkbox"/> My skin tends to flush easily and has a reddish or yellowish shade.	<input type="checkbox"/> My skin is thick, smooth, and often tends to feel damp or oily.	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"/>		
Skin	<input type="checkbox"/> When I have rashes, they tend to be dry and itchy. Blemishes are usually blackheads.	<input type="checkbox"/> When I have rashes, they tend to be red and burning. Blemishes are usually acne.	<input type="checkbox"/> When I have rashes, they tend to be wet and oozing. Blemishes are usually white pimples.	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"/>		
Sleep	<input type="checkbox"/> I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep.	<input type="checkbox"/> I tend to sleep soundly and awaken with ease.	<input type="checkbox"/> My sleep tends to be deep and long. It can be difficult for me to awaken in the morning.	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.	<input type="checkbox"/> Under stress, I often become irritable but usually rise to the challenge.	<input type="checkbox"/> Under stress, I often withdraw to observe or become reclusive.	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"/>		
Decision Making	<input type="checkbox"/> I am changeable and often have difficulty making decisions.	<input type="checkbox"/> I make decisions easily, but can change my mind with new information.	<input type="checkbox"/> I am careful, but easy-going about decisions.	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"/>		
Projects	<input type="checkbox"/> I like to start projects, but at times have difficulty finishing them.	<input type="checkbox"/> I like to start and finish projects. Completion is important to me.	<input type="checkbox"/> I like working on a project, but prefer to let others start them.	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"/>		
Personality	<input type="checkbox"/> When I am balanced, I feel creative, enthusiastic, and vivacious.	<input type="checkbox"/> When I am balanced, I feel perceptive, disciplined, and logical.	<input type="checkbox"/> When I am balanced, I feel nurturing, calm, and devotional.	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"/>		

**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>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:**



**(15) 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?