Ayurveda

Client In-Take Form

Welcome, Please take a few moments to tell us about yourself.

Name: ____ **Date:** ________
Address: ____
City: __________________________ **State:** _____________ **Zip:** __________

Parent/Guardian: ____
Referred By: ____

Home Phone: _______________ **Work:** _______________ **Cell:** ____________
Email: ____

Date of Birth: __________________ **Age:** _____
Weight: _____ **Height:** _____ **# of Children:** _____ **# of Siblings:** _____

Marital Status: O **Married** O **Single** O **Separated** O **Divorced** O **Widow(er)**

Occupation/School: __________________ **Employer:** ____________________

How did you hear about us ____
Why did you choose CDBY? ____

Please list current complaints in order of severity:

1. ____ For how long? _____
2. ____ For how long? _____
3. ____ For how long? _____
4. ____ For how long? _____
5. ____ For how long? _____

Check the time of day you feel the most energy or the least symptoms:		
O 7am-9am	O 3pm-5pm	O 11pm-1am
O 9am-11am	O 5pm-7pm	O 1am-3am
O 11am-1pm	O 7pm-9pm	O 3am-5am
O 1pm-3pm	O 9pm-11pm	O 5am-7am

Check the time of day you feel worst or when symptoms are aggravated:		
O 7am-9am	O 3pm-5pm	O 11pm-1am
O 9am-11am	O 5pm-7pm	O 1am-3am
O 11am-1pm	O 7pm-9pm	O 3am-5am
O 1pm-3pm	O 9pm-11pm	O 5am-7am

Check symptoms that apply:

O Headaches	O Disinterest in Sex	O Digestive problems
O Neck pain	O Irritability	O Lightheaded
O Neck stiffness	O Chest pain	O Lower back pain
O Pins & Needles	O Dizziness	O Vomiting
O Itching/Rash	O Shortness of breath	O Depression
O Numbness	O Sleeping problems	O Incontinence

O Other: ______________________________

Date of last Physical Exam: ____________ **Family Physician:** ____________________

Do you wear:

O **Corrective lenses** O **Dentures** O **Hearing Aid**

O **Medical Devices/prosthetics/implants** (*describe*):

____

____

____

Circle the level of stress you are experiencing on a scale of 1 - 10
(*1 being the lowest, 10 being highest*):

1 2 3 4 5 6 7 8 9 10

Have you had an unintentional weight loss or gain of 10 pounds or more, in the last three months?

O **Yes** O **No**

What medications are you currently taking?

______________________________ for: ____________________
______________________________ for: ____________________
______________________________ for: ____________________
______________________________ for: ____________________

Please list major hospitalizations, injuries, surgeries, illnesses & car accidents:

Year	Procedure/injury	Outcome
____	____________________	____________________
____	____________________	____________________
____	____________________	____________________
____	____________________	____________________

Family History

	Diabetes	Heart Disease	Cancer	Back Pain	Headaches	Notes:
Mother	☐	☐	☐	☐	☐	____________
Father	☐	☐	☐	☐	☐	____________
Sibling(s)	☐	☐	☐	☐	☐	____________
Grandparents	☐	☐	☐	☐	☐	____________

Health Habits:

O **Tobacco:** Cigarettes: #/day: ___
Cigars: #/day: ___
O **Alcohol:** Wine: #glasses /day or wk: ___
Liquor: #oz/day or wk: ___
Beer: #glasses/day or wk: ___
O **Caffeine:** Coffee: #6oz. cups/day: ___
Tea: #6oz. cups/day: ___
Soda: #8oz. Cups/day: ___
O **Water:** #glasses/day: ___
O **Other:** ______________________________

Exercise:

O **5-7 days per week**
O **3-4 days/week**
O **1-2 days/week**

O **45+ min. duration/workout**
O **30-45 min. duration/workout**
O **Less than 30 min.**

O ***Walk***
O ***Tennis***
O ***Swim***
O ***Hike***
O ***Run, jog, jump rope***
O ***Weights***
O ***Yoga***
O ***Other:*** ___________

Nutrition & Diet

O **Mixed food diet (animal & vegetable sources)**
O **Vegetarian (no animal products whatsoever)**
O **Salt restriction**
O **Fat restriction**
O **Starch/carbohydrate restriction**
O **Total calorie restriction**
O **Commercial diet (which one?): _______________**
O **Other: ___________________________________**

Eating Habits

O **3 square meals/day**
O **Skip breakfast**
O **Two meals/day**
O **One meal/day**
O **Graze (small frequent meals)**
O **Food Rotation**
O **Eat constantly whether hungry or not**
O **Generally eat on the run or while distracted**
O **Add salt to food**
O **Snacks**

Specific Food Restrictions/Allergies:

O **Dairy** O **Wheat** O **Soy** O **Eggs** O **Corn** O **All Glutens**
O **Other: ____**

Would you like to:

O **Have more energy**
O **Be Stronger**
O **Have more endurance**
O **Increase your sex drive**
O **Be thinner**
O **Be more muscular**
O **Improve your complexion**
O **Have strong nails**
O **Have healthier hair**
O **Be less moody**
O **Be less depressed**
O **Be less indecisive**
O **Feel more motivated**
O **Be more organized**
O **Think more clearly and be more focused**
O **Improve memory**
O **Do better on tests in school**
O **Stop using laxatives or stool softeners**
O **Be free of pain**
O **Sleep better**
O **Have agreeable breath**
O **Have agreeable body odor**
O **Have stronger teeth**
O **Get fewer colds & Flu**
O **Get rid of your allergies**
O **Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.**
O **Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)**

Current Supplements:

O **Multivitamin/mineral**
O **Vitamin C**
O **Vitamin E**
O **Vitamin D**
O **EPA/DHA**
O **Evening Primrose/GLA**
O **Calcium, source: ____________________**
O **Magnesium**
O **Zinc**
O **Minerals, describe: __________________**
O **Friendly flora (acidophilus) Probiotics**
O **Digestive enzymes**
O **Amino acids**
O **CoQ10**
O **Antioxidants (e.g., lutein, resveratrol, etc.)**
O **Herbs-Teas**
O **Herbs-Extracts**
O **Chinese Herbs: ______________________**
O **__________________________________**
O **Ayurvedic Herbs: ____________________**
O **__________________________________**
O **Homeopathy: _______________________**
O **__________________________________**
O **Bach flowers**
O **Protein shakes**
O **Superfoods (bee pollen, phytonutrient blends)**
O **Liquid meals (e.g., Ensure)**
O **Other: _____________________________**

Signature (Client or Guardian) ___________________________ Date: ________

Client Record of Disclosure

In general, the HIPAA privacy rules individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please contact me with protected health information (PHI) in the following manner. (This does not include appointment confirmation calls or other general administrative information):

O **Home Telephone :**______________________________
O **OK to leave message with detailed information**
O **Leave message with call-back number only**

O **Work Telephone :**______________________________
O **OK to leave message with detailed information**
O **Leave message with call-back number only**

O **Written Communication**
O **OK to mail to my home address**
O **OK to mail my work/office address**

O **Other :** ______________________________
____
____
____

Signature (Client or Guardian) ________________________________ Date: _______

Print Client's Name ____

Print Guardian's Name ____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. **Note: Uses and disclosures of information may be permitted without prior consent in an emergency.**

For office use only:

Record of Disclosures of Protected Health Information

Disclosed to whom	Date	Address or Email	(1)	Description & purpose of disclosure	Type (2)	Disclosed by whom	Type (3)

(1) Check this box if disclosure is authorized by client or legal guardian.
(2) Type key: T=Treatment Records, P=Payment Information, A=Authorized on File, O=Other
(3) Enter how disclosure was made: F=Fax, P=Phone, E=Email, M=Mail, O=Other

Ayurvedic Consults

Disclosure, Release, & Waiver of Liability Agreement

I, the client, acknowledge that I have read and understood the contents of this agreement.

1. Leslii Stevens and CoyDog Botanicals & Yoga make no representations, claims, or guarantees regarding the efficacy of her recommendations. The recommendations are based upon a combination of her clinical experience in the Commonwealth of Massachusetts and knowledge of natural health literature. A natural health consultation as provided by Leslii Stevens does not constitute a medical service or health care treatment.
2. I also grant permission to Leslii Stevens to perform such assessments and therapeutic recommendations as are considered necessary or advised for my plan. I understand that I may look at my record at any time and may request a copy of it. I understand that the nature of the recommends for my care will be explained to me and that I will have the opportunity to ask questions to those involved in my care. I am not being forced to accept treatment.
3. Individualized recommendations are offered and applied as as educational and informative consultation. Any action taken as as result of the consultation is done at the sole discretion of the client. Therefore, it is strongly recommended that in addition to any health consultation that you maintain a relationship with one or more physicians qualified to care for health condition(s). For example, in the case of children, I advise that you seek the advice of a pediatrics; if you have cardiovascular disease, consult with a cardiologist; and if you have cancer, consult with an oncologist, etc.
4. Your signature verifies that you have not been told to discontinue treatments with any medical specialist or other health care providers. Your signature is being given prior to rendering any service, advice, and/or recommendations whatsoever.
5. Financial Policy: Clients are fully responsible for all professional services, herbs, supplements, or equipment received. We are not contracted with insurance companies and do not bill for services. I, the undersigned, understand that I am responsible for all charges. I understand that failure to pay is illegal. A). We will collect full payment for any nutritional supplies, supports, and any therapeutic appliances the day they are recommended. B). We will charge a $25 fee for any returned checks. C). Office Visit Cancellation: We require a 24-hour (business day) advance notice of an office visit cancellation. There is a 50% fee for visits not cancelled 24 hours (business day) in advance.
6. Supplements: We have available nutritional supplements and other health products. You are in no way obligated to purchase these products from this office or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish.

By printing and signing my name, I agree to comply with the above polices and acknowledge that I understand all terms, verbiage (language) and concepts herein. **I understand this consent agreement and have executed it freely and willingly.**

Signature ____Date: ________

Print Name ____

Print Guardian's Name ____

Signature of Guardian's Name ____

Confidential Patient File Disclosure Agreement

I, the undersigned client, acknowledge that I have read and understood the contents of this agreement.

I give Leslii Stevens ERYT500, YACEP, Ayurveda Practitioner, CoyDog Botanicals & Yoga, its officers and employees the right to publish my health history as a case study for educational purposes. I understand that my name will be kept anonymous and all my account information will remain confidential.

By signing my name below, I agree to comply with the above disclosure and acknowledge that I understand all terms, verbiage (language and concepts herein. **I understand this consent agreement and have executed it freely and willingly.**

Signature ____ Date ________

Print Name ____

Print Guardian's Name ______________________________________

Signature of Guardian's Name _________________________________