YOGA THERAPY CENTER
& SHIVASHAKTILOKA

Ayurvedic

your personal story

Health Analysis

415.939.8261 www.yogatherapycenter.org 3341 Clement Street ,San Francisco, CA 94121

here's how

This information will help me have insight in to your current lifestyle, diet and complaints, as well as uncover the root cause of your challenges to personalize the recommendations.

Print this questionnaire and bring it with you on your Ayurvedic consultation with Chinnamasta.

The day of your appointment do not take any supplements for 2 meals before the consultation. However, DO continue to take any medication prescribed by your physician.

confidential information

Date		Referred By:	
Name	Male or Female	Birthdate:	Age:
Mailing Address:	Street:	City/State	Zip
Daytime Phone:		Evening Phone:	
Height:	Weight:	Marital Status: S/M/D/W	No. Children:
Occupation:			

contact me

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personal health goals

1 How important is your health to you? (*from 1 to 10, 10 being the highest):*

2 How much confidence do you have in your bodies ability to heal itself if given the right nutrients and natural therapies? (*from 1 to 10, 10 being the highest):*

3 How much confidence do you have in prescribed pharmaceuticals(*from 1 to 10, 10 being the highest):*

How long do you want to live? (*circle one*)

a) Age 60-70, age 70-80, age 80-90, age 90-100
b) As long as I am healthy, as long as I am granted, until I complete my purpose on earth
c) Only if my significant other is alive also
d) Forever
e) It is already enough

4 Do you want to lose weight? If so, how much?

5 What are your specific health goals?

6 Describe what you hope to gain from the session:

7 To what extent are your willing to change and commit to achieve your health goals

a) Don't want to change much
b) Willing to change some
c) Willing to change a reasonable amount
d) Willing to do whatever it takes

8 On the average, how much do you spend per month for your health and for supplements?

9 What is the monthly budget that you are willing to spend on supplements and natural therapies to achieve your personal health goals?

history questionnaire

Please answer the following confidential questions as truthfully as possible. Always keep in mind that you are observing your current state of the body, mind and heart, when answering the questions.

1 Please rank your current complaints and rate their severity

(from 1 to 10, 10 being the most severe):

2 Please tell us any additional information or concerns about your health:

3 Please list any medications, herbs and/or supplements you are currently taking and how long you have taken them *(including birth control pills, aspirin, pain medications, etc*

4 Do you currently smoke? _____If yes, how much?

How long have you smoked?_____

5 What surgeries, operations, traumas, car accidents, etc. have you had?

a.) Have you ever had full-body anesthesia (i.e. *to remove tonsils, wisdom teeth, etc.*)?

b) Do you have breast implants?

c) Other surgical implants or prostheses?

d) Have you had elective surgery *(tummy tuck, face-lift, burned off moles, liposuction, etc.)*?

e) Do you have any metal or plastic inside your body *(such as pins, clamps, plates, etc.)*?

f) Do you have pierced ears or other body piercings?

history questionnaire

6 ***This is strictly confidential information.***

Do you currently use recreational drugs?

If so, circle one: marijuana, heroin, uppers , downers

Other?

How Often?

Have you used recreational drugs in the past?

7 Indicate how many of the following you have had:

Silver Filings		Gold Crown or inlays		Root canals		Braces	
Composites		Stainless steel		Root canals with		Bleeding Gums	
Extractions		Porcelain crowns or inlays		Posts		Sensitive teeth	
Bridgework		DeGussa Porcelain crowns or inlays		Implants		Bad Bite	
Partial or full dentures		Veneers		Temporaries		New cavities	

8 a) Have you had any teeth extracted (wisdom teeth, four bicuspid extraction, etc.)?

b) Have you had dental surgery (gum surgery, jaw surgery, etc.)?

c) Do you need further dental work? If so, what?

history questionnaire

9 a) How many hours of natural sunlight you receive outside daily?

b) Hours spent daily under fluorescent lights?

10 To determine your electromagnetic exposure, how many hours do you spend daily

a) Working on a computer

b) Talking on the phone

c) Talking on a cellular phone

d) Wearing a headset

e) Wearing a hearing aid

f) Do you wear a pacemaker

g) Riding in a car/truck/vehicle

11 Near electrical equipment for long periods of time (i.e. Power lines, computer, copy machine)

Are there computer, TV, Clock radio or electrical appliance in your bedroom?

Are any electrical appliances left on during the night?

When you sleep, is your head within 10 feet of a plug-in clock (such as on a nite stand)?

Do you sleep with a house alarm on?

12 Do you use a cell phone? If so, how often?

Do you live or work within 1/2 mile of a cell phone tower?

history questionnaire

13 a) What kind of exercise do you do?

a) How often?

a) For how long at a time?

14 a) How often do you wear 100% natural clothing (*cotton, silk, wool, linen, etc.*)

a) Synthetic clothing *(polyester, acrylic, nylon, rayon, etc.)*?

15 Any additional information about your history to include?

Ayurvedic Health Overview: Lifestyle, Emotional, & Mental Status

sleep

a) How many hours per night do you sleep?

b) At what time do you go to bed?

c) Do you have problems with falling asleep?

d) Describe the quality of your sleep light, heavy, irritated, dreams, night sweats?

e) If you wake up why, when and how many times do you wake up?

f) Do you wake up refreshed or lethargic

g) Do you wake up without an alarm.? If so at what time.

appetite

a) How is your appetite (agni) low, average or strong?

b) How do you feel after a meal, energized or sleepy?

c) Do you rest after a meal?

d) Do you experience bloating, nausea, thirst, burping, acidity during the day?

e) If so, describe:

f) Hydration, how many glasses of water do you drink per day?

g) What is the total amount of liquid intake per day?

h) Do you drink purified or tap water?

Ayurvedic Health Overview: Lifestyle, Emotional, & Mental Status

digestion

a) When you wake up your tongue looks coated, white or pink?

b) How much time do you take to chew and finish your meal?

c) Do you eat seated, standing, in silence or watching TV, or talking

d) Two-three hours after eating do you experience thirst?

e) Do you experience gas?

energy level

a) Describe your energy level, low, high, or intermittent?

b) When do experience the most energy in the day?

c) In what environment do you feel the most energized?

d) What nutrition energizes you the most?

e) What do you do to restore your energy level?

elimination

a) Do you have stools daily? If so, when and how many time per day?

b) Is the scent foul or not?

c) Is there mucous or gas coming with the stools?

d) What is the quality, banana ripe, diarrhea or hard?

e) Are the stools floating or sinking?

f) What is the color of the stools?

urine

a) How many times per day do you urinate?

b) Does your urine have smell or color? if so describe.

c) How many times do you urinate during the night?

sweating

a) Do you sweat easily? If so, when?

b) Do you have night sweats?

menstruation

a) Do you menstruate? If so is it regular?

b) How long does the menstruation last?

c) Describe any symptoms associated with menstrual cycle.

d) Are you pregnant? If so, how long.

e) Are you breastfeeding?

f) Are going through menopause?

g) Did you have a hysterectomy? If so, when?

h) Any additional comments?

Ayurvedic Health Overview: Lifestyle, Emotional, & Mental Status

emotional state

a) How are you feeling (happy, depressed, sad, angry, subdued)?

b) Other?

mental state

Describe your current mental state (serene, disturbed thoughts, worries, repetitive thoughts, ability to calm down the mind).

Lifestyle

a) Do you spend time in nature? If so how often.

b) Do you like animals?

c) What is your stress level?

d) Describe how you reduce or manage your stress level.

e) Describe the biggest stress factors in your current life.

f) Are there any major changes that have occurred in the last two years in your live (illness, divorce/marriage, death, change of job/environment, operation, move, children, emotional changes). If so, describe.

Ayurvedic Health Overview: Lifestyle, Emotional, & Mental Status

toxic body exposure

Review the labels on these products. Indicate which are non-organic and/or contain chemicals, if any? (note: if you don't understand the words most likely it's chemical)

Shampoo?	Shave Cream?
Deodorant?	Dish Washing: Liquid/Powder?
Toothpaste?	Laundry Soap?
Soap?	Tub/Tile Cleaner?
Hand/Body Lotion?	Glass Cleaner?
Facial Cleanser/Moisturizer?	All Purpose Cleaner?
Hair Spray/Gel?	Perfume/Cologne?
Personal (sexual) lubricant?	Roach/Ant Spray?
Contraceptive jelly/spermicide?	Toilet Freshener?
Hair Dye?	Hair Permanent?
Fingernail/Toenail Polish?	Face make-up/ Eye make-up
Any other past or current chemical exposure?	

household vastu

a) What type of sheets, blankest, pillows and mattress do you use *(100% cotton, polyester, wool)*

b) What direction does the top of your head point when you sleep (north, south, east, west)?

c) What appliance(s) do you use (eclectic stove, gas, microwave, water purifier, air purifier)

d) Does your shower filter protect for chlorine?

e) When was your filter last changed

f) Do you have pets?

g) If so, is it allowed in the house? In the bed?

Food Choices

Circle each type of food that you eat often (once a week or more):

Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food

Red meat *(beef, pork, lamb):* a) grown b) naturally raised

Chicken: a) commercially grown b) naturally raised

Turkey: a) commercially grown b) naturally raised

Fish: a) canned tuna b) fresh fish c) frozen fishd) at restaurants

Fresh vegetables: a) commercially grown (*store-bought*) b) organically grown (*store bought*) c) organically grown (*direct from farmers)*

Fresh fruit: a) commercially grown *(store-bought)* c) organically grown *(store-bought)* c) organically grown *(direct from farmer)*

Whole grains: a) commercially grown *(store-bought)* b) organic *(store-bought)* c) organic (*direct from farmer*) commercially

Whole beans: a) commercially grown *(store-bought)* b) organic *(store-bought)* c) organic (*direct from farmer*)

Eggs/ Butter: a) commercial eggs *(store-bought)* b) organic eggs c) commercial butter d) organic butter

Milk: a) commercial milk b) organic pasteurized milk c) organic goat's milk d) raw milk

Cheese: a) commercial cheese b) organic aged cheese *(store-bought)* c) raw goat or cow's milk cheese

Other: A) commercial ketchup, mustard, spices b) commercial vinegar c) commercial olive oil d) PRL Olive Oil

Ayurvedic Health Overview: Lifestyle, Emotional, & Mental Status

Food Stressors

Please indicate how many times per week you consume the following foods

Stimulants		**Toxic Oils**		**Commercial Dairy**		**Highly Heated Foods**	
Coffee *(including decaf.)*		Fried foods		Cow's Milk		Bread *(store-bought)*	
Black tea, caffeine drinks		Fast food		Yogurt		Crackers *(store-bought)*	
Soft drinks *(colas, etc.)*		Potato or corn chips		Ice cream		Bagels *(store-bought)*	
Drinks with NutraSweet		Roasted nuts		Cottage cheese		Buns *(store-bought)*	
Alcohol *(wine, beer, etc.)*		Mayonnaise		Sour cream		Pasta *(store-bought)*	
Chocolate		Margarine		Cheese *(commercial)*		Muffins *(store-bought)*	
Candy, pastries, sweets		Peanut butter *(commercial)*				Cookies *(store-bought)*	

Food Habits

A) Do you avoid food/drinks that list "natural flavors" *(which means hidden MSG)* on the label?

B) What describes your overall diet: (*circle all that apply*)

a) mostly eat fast food b) mostly eat out, but eat healthier items, c) eat whatever is available d) occasionally binges e) would never give up meat d) regularly eat left overs e) mostly eat fresh foods f) mostly eat home made meals g) vegetarian f) vegan g) mostly eat organic f) mostly eat raw foods i) in transition to eating better

C) Which applies most: *(circle one)*

a) skip meals often b) have irregular eating times c) eat food past 7 PM

typical diet

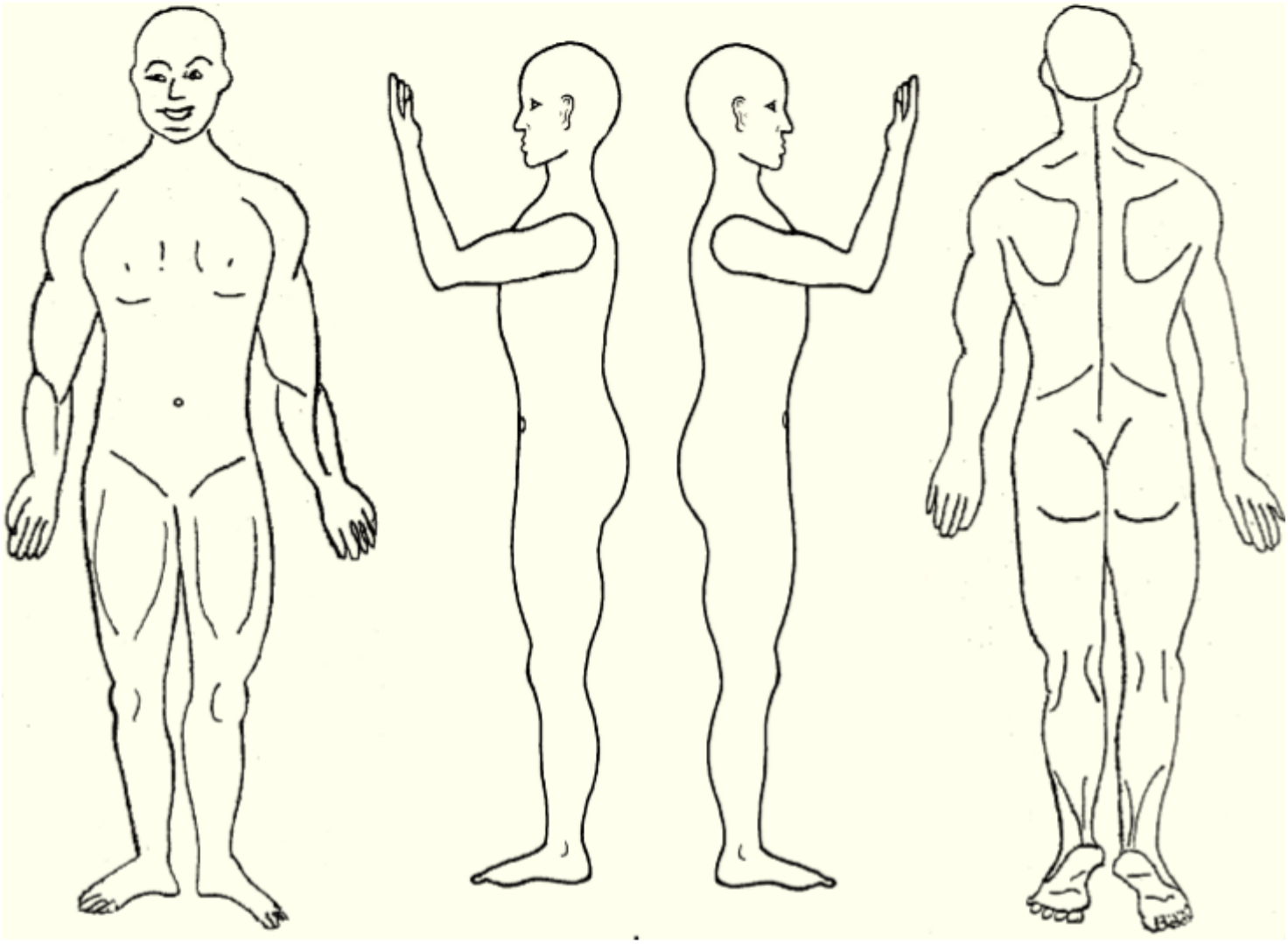
List your typical diet for the last few weeks. Please be as detailed as possible.

Breakfast: (what time_____)
Lunch: (what time _____)
Dinner: (what time_____)

Scar/Trauma Chart

Name: _____

Date: _____



Directions

All Scars. Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, etc.

All Trauma Areas. Please put a red "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury. Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

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