Holistic Ayurvedic Consultation
Confidential Intake Form
Men's Health

Date of Initial Visit_____

Name:_____

Address_____

State_____Zip_____ Home Phone_____

Work Phone_____Cell_____email_____

Date of Birth_____ Age_____Occupation_____

Marital/Relationship status_____Referred by_____
Emergency Contact:

Name_____ Phone:_____

Relationship: _____

Client Confidentiality and Release Form
I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.
I understand that Pilar Chandler has been trained and is certified as a Holistic Health Practitioner and Ayurvedic Practitioner, both of which do not currently have a licensing body in the state of California. California Senate Bill SB-577 allows for professionals to practice their healing art within their scope of practice.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name)_____
give my permission, for my practitioner to take notes including health history/ medical and /or personal information I choose to disclose to him/her. I understand this information may be used for the purpose of practitioner certification and/or may be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, social security number, date of birth.

I agree to give notice of any change in my scheduled appointment time via phone, email or text **48 hours** before my appointment to avoid being charged in full for my scheduled time.

I agree that payment is to be received at the time of service. Cash, check and credit / debit card payments accepted. I understand that if I choose to pay with credit or debit card there is a 3% convenience fee added.

Client Signature: _____ Date: _____

Practitioner signature_____Date:_____

Reason For Visit

Primary reason for visit:_____

When did your first notice it?_____What brought it on?_____

Describe any stressors occurring at the time_____

What activities provide relief?_____what makes it worse?_____

Is this condition getting worse?_____interfere with work_____sleep_____ recreation_____

Have you had massage/bodywork before?_____ What type?_____

Medical History

Are you currently under the care of another health care provider(s)?_____Reason (s)_____

_____

Name(s) of Practitioner_____Address:_____

Phone_____email_____

Current Medications and /orSupplements/Remedies:_____

_____

Allergies: specify allergen and reaction:_____

Surgical History (year and type) and/or Recent Procedures:_____

_____

Hospitalizations: _____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/tailbone (describe)_____

Other:

 Please review and check the following:

Headaches Type:	Past	Present	Numbness in feet or legs when star	Past	Present
Asthma			Sore heels when walking		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Low Back Pain			Muscular Tension: Location:		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Herniated/Bulging Discs		
Painful/Swollen Joints			Artifical/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Family History

	Still Living?	**Cause and Age of Death**	**Major Health Issues**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Gastro-Instestinal Health

Describe your typical:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____Water Intake(glasses/day)_____Caffeine_____

What is the worst item in your diet_____What foods are your weakness_____

Are you subject to binge eating?_____What foods_____

Do you experience bloating/gas/burps after eating?_____What foods trigger this?_____

Food Allergies?_____Describe_____

What foods do you avoid and why?_____

How often are your bowel movements?_____Do your stools: sink_____float_____

Constipation?_____Blood in stool ?_____Mucus in stool?_____Pain when stooling?_____

Diarrhea?_____Other?_____

How many times during the day (average) are you urinating?_____ do you wake at night to urinate? How many times?_____

Please check the boxes that apply.

	Type	Daily	Weekly	Sometimes	Never
Wheat, gluten products					
Whole grains (quinoa, Rice, etc)					
Corn					
Nuts, seeds					
Legumes, beans					
Vegetables					
Fruits					
Eggs, Dairy					
Poultry (chicken, turkey)					
Seafood					
Meat (beef, lamb, pork)					
Sugar, honey					
Deserts					
Processed foods					
Restaurant Food					

Lifestyle, Emotional & Spiritual

What is your opinion of yourself?_____

Describe the most positive emotion you experience_____

When and Where do you experience this emotion?_____

Describe the most negative emotion you experience_____

When and Where do you experience this emotion?_____

Do you have a Spiritual and/or Religious practice:_____

Do you feel satisfied with your life's path? _____

Do you feel supported in your life's goals, dreams, ambitions?_____

On a scale of 1 – 10 (1 being lowest / worse, 10 being highest / greatest) Please rate these areas of relationship:

Co-workers / Community: _____ Friends: _____ Family:_____ Self:_____ Higher Power:_____

What hobbies/ activities provide you with pleasure and accomplishment _____

Describe your exercise routine (type, frequency)_____

What changes would you like to achieve in 6 months:_____

One Year**:**_____

Do you use Tobacco?_____ Quantity_____/ppd Alcohol?_____Quantitiy_____ounces/ day

Marijuana?_____Quantity_____Other:_____ Have you been under treatment for substance use?_____

How would you describe your sleep experience?

Sound, normal duration_____ Light, interrupted_____ Not enough_____

Too heavy and/or too long_____ Difficulty falling asleep_____ Difficulty waking up_____

Awaken too early_____ Frequent nightmares_____

What time are you typically in bed? _____ What time are you up in the morning? _____

How do you generally feel when you wake in the morning?

Fresh and rested_____ A little tired_____ Moderately tired_____Very tired_____

How regularly do you follow your ideal routine (i.e., go to bed early, eat meals on time, exercise regularly)?

Very regularly_____ Somewhat regularly_____ Irregularly_____

How would you rate your usual energy level?

Very high_____ High_____ Moderate_____ Low_____ Very low_____

Male Reproductive Health

Please check the symptoms below that apply

Painful Urination	Past Present	Urinary Retention	Past Present
Urinary Incontinence or Dribbling		Difficult starting or holding urine stream	
Weak or Interrupted Urine flow		Blood or pus in urine	
Pain or Burning with Urination		Pelvic pressure	
Nocturnal Urination How many times?		Insatiable sex drive	
Pain in lower back, esp After intercourse		Pain or Discomfort Between scrotum and Testicles	
Pain or Discomfort in: Penis Testicles Rectum		Pain or Discomfort in Inner thighs: Left Right Both	
Frequent Bladder or Kidney Infections When?		Erection: Difficulty in Obtaining Maintaining Painful ejaculation	

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known)_____Date done_____

Family History of Prostate Disease: Yes___No___Type_____Relationship_____

Family History of Cancer Yes____No_____Type_____Relationship_____

Sexually transmitted disease Yes___ No___ Type if Known_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have a history of rape?_____ trauma?_____ incest_____Describe _____

Did you undergo counseling for this _____

What was this like for you _____

Additional Comments: