ImmuniTree

Ayurveda Wellness for Mind, Body and Spiritual Health

Ayurvedic Holistic Health Analysis Questionnaire

As Ayurveda/ preventive health consultations require at least three to four visits to assess health patterns and make changes in diet, lifestyle, etc., are you willing to commit to at least three visits?
☐ yes ☐ no

Date: _____ Name: _____ Signature: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced

Age: _____ Height: _____ Weight (lbs): _____ Occupation: _____

Date of birth: ..... Time of birth ..... Place of birth .....

Address: .....State..... Zip .....

Phone: ..... E-mail :.....

Why are you interested in an Ayurvedic consultation? .....

How did you hear about Ayurveda?.....

Please describe your present health problems?

1.....

2.....

3.....

4.....

5.....

6.....

7.....

8.....

9.....

10.....

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How long have you had the chronic conditions about which you are consulting us?
☐ less than 6 months ☐ 6 months to 2 years ☐ 2 to 5 years ☐ more than 5 years

How has your health problem progressed since it began?
☐ stable ☐ gradually improving ☐ rapidly improving ☐ fluctuating
☐ gradually worsening ☐ rapidly worsening

Please explain the overall intensity of your symptoms?
☐ very severe ☐ severe ☐ moderate ☐ mild

Is your sleep disturbed by the symptoms?
☐ not at all ☐ somewhat ☐ moderately ☐ severely ☐ very severely

To what extent are you having any degree of bodily pain or discomfort?
☐ not at all ☐ mild ☐ moderate ☐ severe ☐ very severe
How often are you having pain or discomfort?
☐ daily ☐ less than once a week ☐ a fee times per week ☐ several times a day
☐ most or all the time

How long does the pain or discomfort last on the average?
☐ no pain ☐ 10-15 minutes or less ☐ about 30 minutes ☐ about one hour
☐ more than one hour ☐ most of the day

Are you currently under the care of family physician or any other health professional?
☐ yes ☐ no
If yes, mention details .....

What is their opinion about your health?
☐ easily cured ☐ difficult to cure ☐ incurable ☐ did not say

Have you undergone any investigations for blood, urine, stools, x-ray, ultra-sound, MRI etc?
If yes, please specify in detail.....

Are you currently taking any medications and/or receiving any medical treatment for your health condition? If so, please list all medications/treatments and their dosage and what they are for:

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Do you have any past medical history?

If yes, please specify the age of occurrence, duration and its treatment.

Is there a family history of this health problem? ☐ Yes ☐ No
If yes, please specify

Family History-please list parents', grandparents (if available), siblings' health pertinent health history and cause of death, if known:

How severe are your symptoms? ☐ very severe ☐ severe ☐ moderate ☐ mild

Are you allergic to any substances? Please specify: food, pollen, dust etc., and any other allergic reactions?

How would you rate your usual energy level?
☐ very high ☐ high ☐ moderate ☐ low ☐ very low

Describe your bowel movements?
☐ once every 2-3 days ☐ once daily ☐ 2-3 times per day
☐ first thing in the morning ☐ late in day ☐ immediately after meals
☐ immediately after dinner ☐ need laxative daily ☐ other, please specify .....
☐ soft ☐ medium ☐ hard ☐undigested food particles
☐ hemorrhoids ☐blood in stool ☐frequent diarrhea

Do you have any of the following urinary problems?
☐ pain ☐ burning sensation ☐ discoloration ☐ other discharges

☐ frequent urination during the day ☐ urination several times during the night
☐ urine retention

Do you delay or suppress any of the following?
☐ bowel movements ☐ gas ☐ urination ☐ sleep ☐ yawning
☐ burping ☐ breathing ☐ sneezing ☐ hunger ☐ thirst

Do you practice any type of Meditation and Yoga technique? Please explain?Frequency?

What is your present state of mind and emotions? ☐ good ☐ fair ☐ poor

Do you often experience any of the following?
☐ worry ☐ anxiety ☐ fear or panic ☐ loneliness
☐ depression ☐ high stress level ☐ lack of memory ☐ light headedness
☐ lack of energy

Do you get up early? ☐ Yes ☐ No At what time..... how many hours of sleep?.....

Do you go to bed early? ☐ Yes ☐ No At what time.....

Do you sleep in the daytime? ☐ Yes ☐ No
Do you have trouble getting to sleep? ☐ Yes ☐ No

If you wake at night, what time and how long?.....

How often do you wake up in the middle of night per week and not fall back asleep quickly?.....

How much time (combined computer, cell phone, tablet, ibook, TV) do you spend on screens per day?_____

How long before bed do you stop using screens?_____

How do you generally feel on arising in the morning?
☐ fresh and rested ☐ a little tired ☐ moderately tired ☐ fairly tired

How is your sleep?
☐ sound, normal duration ☐ light, interrupted ☐ too little sleep
☐ too heavy and or too long ☐ difficulty falling asleep ☐ difficulty waking up

☐ awaken too early ☐ frequently nightmares

What is the direction of your head during sleep?
☐ East ☐ West ☐ North ☐ South
☐ Northeast ☐ Northwest ☐ Southwest ☐ Southeast

What is your sleeping position?
☐ on your back ☐ on your tummy ☐ left side ☐ right side
☐ other, please specify.....

How regular is your daily routine (for example, do you go to bed early, eat your meals on time, exercise regularly etc?) Please specify:
☐ very regular ☐ somewhat regular ☐ irregular

What is your body build? ☐ thin ☐ large ☐ average ☐ muscular

Are you overweight? ☐ yes ☐ no If so, by how much?
☐ Less than 15 pounds ☐ 15-30 pounds ☐ 30-50 pounds ☐ more about 50 pounds

Do you travel a lot? ☐ yes ☐ no
What type of travel and how often?.....

How often do you exercise?
☐ weekly once ☐ weekly twice ☐ weekly thrice ☐ weekly four times

☐ every day ☐ not at all

How long do you exercise per day? .....

Is your exercise: (choose one)
☐ Vigorous ☐ moderate ☐ light Type of exercise:.....

How much time do you spend outdoors each day total?.....

Do you smoke cigarettes or others? ☐ yes ☐ no (Please say if you smoked in past, how long and when you quit):.....
If yes, how many per day? ½ pack / 1 pack / 2 packs / more than 2 packs

How often do you drink alcohol?
Never / less than once a week / about once a week / several times a week / more than once a day How much and type:.....

What time of day do you drink alcohol?.....

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How often do you drink caffeinated (coffee, tea etc) beverages?
Never / one cup daily / 2 – 3 cups daily / 4 – 5 cups daily

When is your last caffeinated beverage in the day?.....

When you drink caffeinated beverages, are they organic? ☐ yes ☐ no

Which type of weather makes you feel most uncomfortable? (Choose one)
☐ cold ☐ hot ☐ cool and damp

Please explain your typical food habits and preferences?

Breakfast: .....

Lunch: .....

Dinner: .....

Snacks: .....

Do you eat between meals? ☐ Yes ☐ No what type of foods?

Do you eat organic foods primarily? ☐ yes ☐ no

Do you eat your meals on time? (e.g. breakfast around 7:30-9, lunch 12-2, dinner 5-7)
☐ yes ☐ no

Which is your main meal? ☐ breakfast ☐ lunch ☐ dinner

Do you crave any types of food?.....

Rate your digestion: ☐ good ☐ fair ☐ poor

How much water you drink per day?
never / 1-2 glasses / 3-4 glasses / 5-6 glasses / 7 glasses and more

My eating habits include:
☐ eat with full attention on food ☐ talk or converse a lot while eating
☐ watch television while eating ☐ never sit to eat ☐ eat very fast
☐ eating out at restaurants >1-2x week

Do you consume the following (how much and how often)?
Processed foods (breads, pastries, pasta, crackers, etc):

sodas:
candy or chocolate:
raw foods, salad:
cold drinks:
red meat:
spicy food:
fried food:
cheese, nuts:

Describe your diet:
☐ vegan ☐ lacto-vegetarian ☐ ovo-lacto-vegetarian ☐ others, please specify .....
Non-vegetarian: ☐ Beef ☐ pork ☐ chicken ☐ turkey ☐ seafood
☐ eggs ☐ others, please specify .....

Have you experienced any changes in your sense of taste? (Choose one)
☐ loss of taste ☐ sweet taste in mouth ☐ sour taste in mouth
☐ bitter taste in mouth ☐ pungent taste in mouth ☐ not specific

What taste(s) do you like best? sweet / salty / bitter / sour / hot / astringent

Are there any particular foods that create discomfort when you eat them?
☐ sweet ☐ sour ☐ oily or fatty ☐ hot ☐ salty ☐ bitter
☐ astringent ☐ dairy products (including cheese)

How are your family relationships? ☐ Excellent ☐ good ☐ fair ☐ poor

How is your social life? ☐ Excellent ☐ good ☐ fair ☐ poor

How is your mental status? ☐ Excellent ☐ good ☐ fair ☐ poor

What is your current level of stress and what stressors are occurring in your life right now?
(1=minimal, 10 = maximal)?_____

How is your career? ☐ Love it ☐ like it ☐ can stand it ☐ cannot stand it

How purposeful is your life? ☐ Completely ☐ somewhat ☐ neutral ☐ not happy

Rate your spiritual life: ☐ Fully satisfying ☐ somewhat satisfying ☐ neutral ☐ empty
Do you have a spiritual practice? yes no

As a child did you experience any abuse or trauma? ☐ None ☐ emotional ☐ physical
☐ sexual ☐ verbal ☐ other, please explain .....

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What is your ACEs score?_____/10 (please look up on-line and take the test, takes a minute—it's called the Adverse Childhood Events score)

For Women only: (please answer * even if post-menopause)
Which of the following describes your menstruation? (You may choose more than one)
☐ regular ☐ irregular ☐ too frequent ☐ absent ☐ ceased due to menopause

How may days does your menstrual period last?
☐ zero to four days ☐ five to seven days ☐ more than seven days
☐ spotty irregularly throughout the month ☐ others, please expalin.....

Is your menstrual flow? ☐ heavy ☐ light ☐ normal

*Associated symptoms (before or during menstruation or after menopause) –**please answer even if post-menopause**
☐ none ☐ pain ☐ fluid retention ☐ migraine ☐ depression
☐ acne ☐ tension ☐ hot flashes ☐ other, please specify .....

Do you have any discharge outside of your menstrual period? ☐ Yes ☐ No

Are you pregnant now? ☐ Yes ☐ No ☐ Don't know

Do you or have you taken contraceptive pills or other devices in past or present? ☐ Yes ☐ No

Number of previous pregnancies (choose one) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 or more

Do you have any history of abortion, miscarriage, etc?
If yes, explain.....

How many children do you have? ..... Please specify ages: .....
Do your children have any health conditions? Explain.....

If there are any other conditions or questions you would like to add, please do so here:

.....

.....

Could you state the one health/well-being/psychological or spiritual thing you'd like to address most right now in your life?

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.....

Questionnaire regarding level of mind/body impurities. Mark all that apply:

1 = None	**2 = Mild**	**3 = Moderate**	**4 = Severe**

	Score			
I generally feel constipated.	1	2	3	4
I often get congestion in my head and sinuses	1	2	3	4
I often get infections.	1	2	3	4
I feel my immune system is weak	1	2	3	4
I feel non-clarity of mind	1	2	3	4
I feel physically exhausted without any reason	1	2	3	4
I feel mentally exhausted easily	1	2	3	4
My stress levels are	1	2	3	4
I have no desire to eat food	1	2	3	4
I tend to feel indigestion frequently	1	2	3	4
I tend to get lot of salivation in the mouth	1	2	3	4
I easily get angry and irritated without any real reason	1	2	3	4
I feel that my breathing pattern altered	1	2	3	4
I frequently get cold throughout the year	1	2	3	4
I tend to get allergies throughout the year	1	2	3	4
I feel heaviness in the body	1	2	3	4
I feel something is not well in my mind-body	1	2	3	4
Total :				

1 to 17	**= None**	**35 to 51**	**= Moderate**
18 to 34	**= Mild**	**52 to 68**	**= Severe**

Mind Body Self-Evaluation Test

(Please choose suitable choices that apply to you over your ENTIRE life, not just currently)

Vata Personality

( ) I usually perform activity very quickly, enthusiastic, lively by nature, my energy tends to come in bursts.

( ) I have a thin physique – I don't gain weight very easily.

( ) I have always learned new things very quickly and forget easily.
( ) I tend to have difficulty making decisions.
( ) I tend to develop gas and become constipated easily.
( ) I become anxious or worried frequently.
( ) I tend to have cold hands and feet.
( ) I don't tolerate cold weather as well as most people.
( ) I speak quickly, miss words, and my friends think that I'm talkative.
( ) I often have difficulty falling asleep or having a sound night's sleep.
( ) I am easily excitable.
( ) I tend to be irregular in my eating and sleeping habits.
( ) My mind is very active, sometimes restless, but also very imaginative.
( ) My skin tends to be very dry, especially in winter.
( ) My moods change easily, and I am somewhat emotional by nature.
( ) My characteristic gait while walking is light and quick.

Total Vata Score: _____

Pitta Personality

( ) I consider myself to be very effective in my work and activities.
( ) I feel uncomfortable or become easily fatigued in hot weather – more than other people.
( ) In my activities, I tend to be extremely precise and orderly.
( ) I am strong-minded and have a somewhat forceful manner.
( ) I become impatient very easily, people consider me stubborn.
( ) I tend to perspire easily.
( ) I have a strong appetite; if I want to, I can eat large quantities.
( ) I am very regular in my bowel habits.
( ) I get angry quite easily, but then I quickly forget about it.
( ) I am very fond of cold foods, such as ice cream, ice cold drinks.
( ) I am more likely to feel that a room is too hot than too cold.
( ) I don't tolerate foods that are very hot and spicy.
( ) I am not as tolerant of disagreement as I should be.

( ) I enjoy challenges, and when I want something I am very determined in my efforts to get it.
( ) I tend to be quite critical of others and also of myself.
( ) If I skip a meal or a meal is delayed, I become uncomfortable.
( ) One or more characteristics describe my hair – early graying or balding, thin, straight, blond, red or sandy-colored.

Total Pitta Score: _____

Kapha Personality
( ) I tend to gain weight easily and find it difficult to lose weight.
( ) I can easily skip a meal without any difficulty.
( ) I frequently tend to get excess congestion, mucus and sinus problems.
( ) I tend to do things in a slow and relaxed manner.
( ) I feel comfortable if I sleep at least 8 hours daily.
( ) I am calm by nature and not easily angered.
( ) I don't learn as quickly as some people, but I have excellent retention and a long memory.
( ) I have smooth, soft skin with a somewhat pale complexion.
( ) I have a large, solid body build.
( ) I have slow digestion, which makes me feel heavy after eating.
( ) I have very good stamina, physical endurance, steady energy, walk gently and slowly.
( ) I like to sleep more, and I feel tired even though I sleep more and am slow to move in my activities in the morning.
( ) I generally eat slowly and my activities are methodical.
( ) I dislike cool and damp weather, and it bothers me a lot.
( ) My hair is thick, dark, and wavy.
( ) People like to call me sweet natured, peaceful, affectionate, cool, calm minded.

Total Kapha Score: _____

My Mind-Body Personality is: VATA _____PITTA _____KAPHA _____

What are you passionate about? Describe:_____

If you've lost your passion, when did you notice it was gone?_____

Thank you for completing the questionnaire!