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New Patient Intake Form

*If you need to cancel or change your appointment, please do so within 24 hours before scheduled time. Because all of our time is so precious, failure to do so will result in full payment for the missed appointment.*

Name

Age

Email

Address

Phone Number

Occupation

In case of emergency

Married/Single/Divorced

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Chief Complaint(s)

When did complaints begin?

Stress:
(that which was occurring when the complaints started)

- [ ] NOT APPLICABLE
- [ ] Stress - Financial
- [ ] Stress - Marital
- [ ] Stress - School
- [ ] Stress - Work
- [ ] Death of Loved One
- [ ] Divorce
- [ ] New Baby
- [ ] Pregnancy

- [ ] Illness/Injury
- [ ] Sexual Abuse
- [ ] Other Abuse
- [ ] Change of Residence

Medications and supplements

Physical health history

Emotional/psychological history

Childhood illnesses

Family medical illnesses

Current weight

Height

Hair/Nails

Skin

Digestion

Appetite:  Sama/Vishama/Tikshna/Manda

Bowel movements: _____per day

Constipation? Y/N occasionally

Sleep:

regular/irregular:

hours per night

waking in the night

Body temp:

Warm

Neutral

Cold

Exercise: _____hrs per day _____times per week

## Diet / Foods Regularly Eaten:

Past Diet

- ☐ Balanced
- ☐ Poor
- ☐ Gluten Free
- ☐ Dairy Free
- ☐ Vegan
- ☐ Vegetarian
- ☐ Low Carb
- ☐ Paleo
- ☐ Other

For how long_____

Present Diet

- ☐ Balanced
- ☐ Poor
- ☐ Gluten Free
- ☐ Dairy Free
- ☐ Vegan
- ☐ Vegetarian
- ☐ Low Carb

- [ ] Paleo
- [ ] Other

For how long_____

Normal daily food intake:

Breakfast

- [ ] Cold Cereal
- [ ] Hot Cereal
- [ ] Eggs
- [ ] Bacon
- [ ] Sausage
- [ ] Other
- [ ] None/other

Lunch

- [ ] Soup
- [ ] Crackers
- [ ] Fish
- [ ] Chicken
- [ ] Meat
- [ ] Veggies
- [ ] Bread
- [ ] Salad
- [ ] Cold Cut Sandwich
- [ ] NONE
- [ ] Canned food

Other

Dinner

- [ ] Red Meat
- [ ] Chicken
- [ ] Fish
- [ ] Pork
- [ ] Bread
- [ ] Pasta
- [ ] Potato
- [ ] Veggies
- [ ] Other

Snacks

- [ ] Cheese
- [ ] Chips
- [ ] Fruit
- [ ] Nuts
- [ ] Yogurt
- [ ] Other

Beverages x per day x per week

Coffee

- [ ] Tea
- [ ] Soda
- [ ] Juice

Other

Dairy circle what applies

None, whole fat, low fat, skim, soy, nut, oatmeal

None, occasional, daily, other

| | x per day | x per week |
|---|---|---|
| Alcohol | | |
| Smoking | | |
| Pot | | |
| Other drugs | | |
| Prescription drugs | | |
| Processed foods | | |

Preferred tastes: Sweet Sour Salty Pungent Astringent Bitter

Daily Habits you would like to change:

PULSE:

| | | | |
|---|---|---|---|
| RATE : | /MIN | | |
| **BP:** | | | |
| **Rhythm:** | regular | regular/irregular | irregular/irregular |
| **Strength** | Weak | Moderate | Strong |
| **Tridosha** | Superficial | | Deep |

| | | | |
|---|---|---|---|
| Subdosha | V | P | K |
| PUVSA | | PRBSA | KASBT |

TONGUE:

BODY

COATING

CRACKING

PRAKRITI/VRAKRITI

*See attached document*

TREATMENT PLAN:

Dietary changes

Lifestyle changes

Herbal Therapies

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2

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