UlliAyurveda

HEALTH HISTORY FORM

**Welcome!**

Thank you for considering me for your holistic and natural health care needs. In preparation for your consultation, find enclosed a Client Health Profile for you to review, complete and bring with you to your first appointment.

Ulli Ayurveda is a synergistic integration of the one of the oldest, continuously practiced traditions of medicine on the planet–Ayurveda–and modern nutritional and herbal medicine. Ayurveda respects that the human body, mind, spirit and soul are an inseparable whole, and essentially comprised of energy and consciousness. It also believes that humans are both deeply connected to and interdependent with nature. Disease is understood in terms of disharmony among the different levels of our existence (body, mind, spirit and soul), or between ourselves and nature.

Respecting the truly holistic nature of our being, I utilize several integrated approaches not only to address specific health issues but also to achieve optimal metabolism and weight, strong immunity, balanced energy, and a clear, calm and positive state of mind:

- Through **Ayurvedic Lifestyle & Diet Consultations**, I will guide you in developing daily routines and eating habits best suited to your metabolic type and the daily and seasonal biorhythms.
- Through **Holistic Herbal Consultations**, I will develop personalized herbal strategies and formulas that will meet the specific needs of your body and mind, using only the highest-quality organic and/or wild-crafted herbs.
- Through educating you in **AyurPrana, AyurYoga, Holistic Nutrition, and Eastern Philosophies**, I will empower you to take better control of your health and achieve personal fulfillment.

To your radiant health and wellbeing.
Yours,

Ulli Allmendinger
MSc Ayurveda

UlliAyurveda

# HEALTH HISTORY FORM

Date: ____ / ____ / _____

**All the information you give will be kept confidential.**

Name : _____

Address : _____

City / Area : _____ Postal Code : _____

Phone : _____ e-mail : _____

Would you like to join our mailing list? ☐

Date of Bith : _____ Time of Birth: _____ Place of Birth : _____

Age : _____ Occupation : _____ Maritial Status : _____

Children & Ages : _____

Main Physician : _____ Phone : _____

What are your main health concerns and when did they begin?

What would you like to achieve in terms of your health and wellness?

Are you currently receiving care from any other natural health professionals? Please provide names.

Are you taking any medications and/or supplements (vitamins, herbs)?

| Name | Purpose | Dose | Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you use any of the following?

Cigarettes? _____ Years _____ Amount _____

Have you smoked in the past? _____ When did you quit? _____

Recreational drugs? _____ What types? _____ How frequently? _____

Alcohol? _____ What types? _____ How frequently? _____

Coffee? _____ Cups per day? _____ Black Tea? _____ Cups per day? _____

Health History:
Have you or a family member been diagnosed with any of the following conditions (check boxes that apply and write when the diagnoses was made):

| Condition | Myself | Family Member Paternal | Family Member Maternal |
|---|---|---|---|
| Allergies | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Chronic Obstructive Pulmonary Disease (COPD) | ☐ | ☐ | ☐ |
| Tuberculosis (TB) | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ |
| Hepatitis A | ☐ | ☐ | ☐ |
| Hepatitis B | ☐ | ☐ | ☐ |
| Hepatitis C | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ |
| Mononucleosis | ☐ | ☐ | ☐ |
| Any Venereal Diseases (STDs) | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ |
| Osteo-Arthritis | ☐ | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ | ☐ |
| HIV / AIDS | ☐ | ☐ | ☐ |
| Psychiatric Disorders | ☐ | ☐ | ☐ |
| Eating Disorder (Anorexia or Bolemia) | ☐ | ☐ | ☐ |
| Stomach Ulcers | ☐ | ☐ | ☐ |
| Crohn's Disease | ☐ | ☐ | ☐ |
| Ulcerative Colitis | ☐ | ☐ | ☐ |
| Celiac Disease | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ |

Please list any other major diseases that you or a family member have been diagnosed with in the past:

List major accidents, injuries, surgeries and/or other hospitalizations and their dates?

Health Profile (Please check anything apply to you and fill in related information)

**General**

Height : _____ Weight : _____ Desired Weight : _____

Significant weight changes in the past _____

Do you exercise regularly? _____ How frequently? _____

Types? _____

How would you describe your overall energy level? ☐ Very Good ☐ Good ☐ Low ☐ Very Low

When in the day is your energy usually highest? _____

When in the day is your energy usually lowest? _____

Body Temperature : ☐ I usually feel cold ☐ I usually feel hot ☐ Usually only my hands / feet feel cold / hot
☐ Usually comfortable; neither too hot or too cold ☐ I prefer warm/hot weather
☐ I prefer cool/cold weather ☐ Other _____

Sweating : ☐ I sweat easily & profusely ☐ I sweat very little or none ☐ I sweat at nights
☐ I sweat normally ☐ Other _____

Food & Drink : Do you feel like you have a healthy diet? ☐ Yes ☐ No ☐ I am not sure
Do you feel like you drink enough water? ☐ Yes ☐ No ☐ I am not sure
☐ Other _____

**Eyes**

☐ Far-sighted ☐ Near-sighted ☐ Astigmatism ☐ Blurred vision ☐ Poor night vision
☐ Floaters ☐ Cataracts ☐ Glaucoma ☐ Pain / soreness ☐ Itching ☐ Tearing
☐ Broken vessels ☐ Other _____

**Ears, Nose, Throat (Majja & Asthi Dhatu, Pranavaha Srotas)**

☐ Frequent Earaches ☐ Poor hearing ☐ Tinnitus
☐ Nasal Congestion ☐ Sinus Congestion ☐ Nasal dryness ☐ Nasal drainage ☐ Nosebleeds
☐ Other _____

**Teeth**

☐ Cavities ☐ Root Canal ☐ Implants ☐ Gum infection ☐ Grinding teeth ☐ Clicking jaw
☐ Jaw pain ☐ Other _____

**Neuro-Psychological (Majja Dhatu, Manovaha Srotas)**

☐ Poor sleep ☐ Poor memory ☐ Difficulty concentrating ☐ Depression ☐ Irritability
☐ Anxiety ☐ High stress levels ☐ Foggy or spacey feeling ☐ Dizziness ☐ Migraine
☐ Headaches ☐ Loss of balance ☐ Lack of coordination ☐ Muscle spasm/twitching
☐ Seizures ☐ Numbness, if yes, where? _____ ☐ Other _____

**Respiratory (Pranavaha Srotas)**

☐ Hayfever ☐ Bronchitis ☐ Asthma ☐ Pneumonia ☐ Pain on breathing ☐ Shortness of breath ☐ Cough
☐ Difficulty breathing when lying down ☐ Mucous in throat Production of phlegm, what color? _____
☐ Other _____

### Immunological (Rasa Dhatu)

☐ Frequent colds, how often? _____ times / year ☐ Canker sores, how often? _____ times / year

☐ Sore throat, how often? _____ times / month ☐ Cold sores, how often? _____ times / year

☐ Swollen glands ☐ Other _____

### Cardiovascular (Pranavaha Srotas, Rasa/Rakta Dhatu)

☐ High BP ☐ Low BP ☐ High cholesterol ☐ Irregular heart beat ☐ Palpitations ☐ Chest pain or pressure

☐ Fainting ☐ Breathing difficulties ☐ Cold hands / feet ☐ Ankle swelling ☐ Easy bruising ☐ Varicose veins

☐ Other _____

### Appetite & Digestion (Annavaha & Purishavaha Srotas)

☐ Very strong appetite ☐ Poor appetite ☐ Food cravings - What kind? _____

☐ Bad breath ☐ Indigestion ☐ Abdominal pain ☐ Heartburn / Reflux ☐ Gas ☐ Bloating

☐ Nausea ☐ Vomiting ☐ Pain / discomfort below ribs ☐ Difficulty digesting fatty meals

☐ Gallstones - When? _____ ☐ Other _____

### Elimination

☐ Diarrhea ☐ Loose stools ☐ Constipation ☐ Blood in stools ☐ Mucous in stools ☐ Black stools

☐ Rectal pain ☐ Hemorrhoids

How frequently do you usually have a bowel movement? ☐ More than 2 times per day ☐ 2 times per day

☐ Once per day ☐ Once every 2 days ☐ Once every 3 days ☐ Less than every 3 days

☐ Other _____

### Muscoskeletal (Mamsa, Asthi Dhatus)

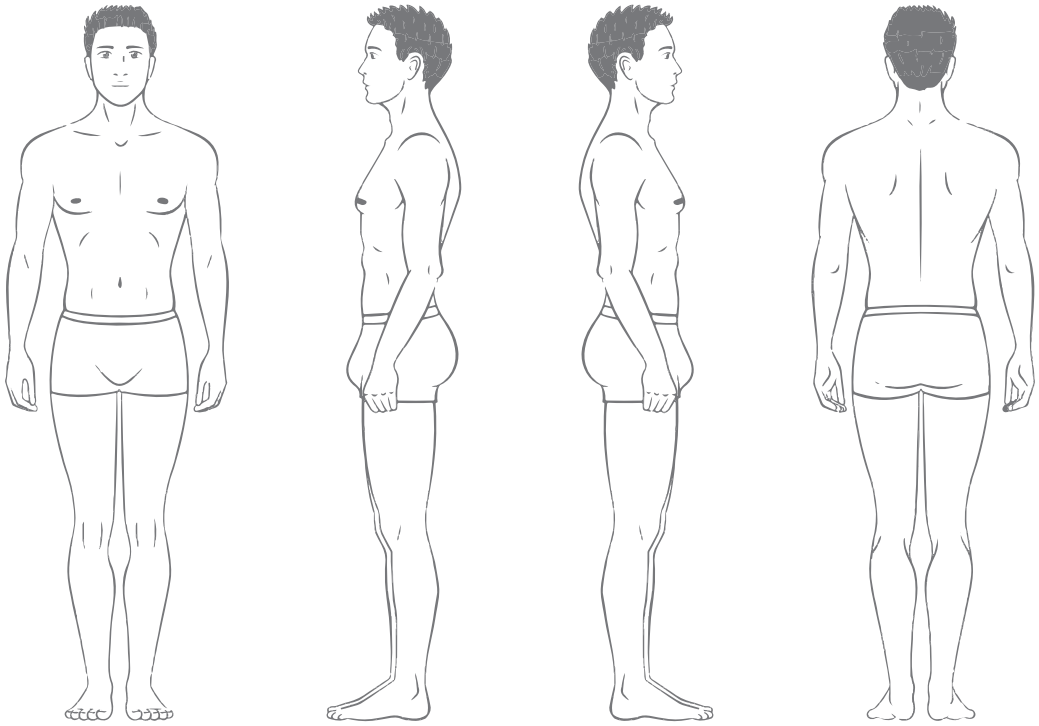
☐ Neck pain ☐ Back pain ☐ Hip pain ☐ Knee pain ☐ Shoulder pain ☐ Pain of arms / legs

☐ Pain of hands / feet ☐ Muscle pain ☐ Muscle stiffness ☐ Muscle weakness ☐ Reduced range of movement

☐ Cracking, popping joints ☐ Joint pain / stiffness ☐ Broken bones ☐ Osteopenia

☐ Other _____

In the diagrams below, please shade all areas where you currently or regularly feel discomfort:



**Skin, Hair, Nails (Rasa, Rakta, Asthi Dhatu)**

☐ Dry Skin ☐ Oily Skin ☐ Pimples ☐ Pustules ☐ Itching ☐ Rashes ☐ Hives ☐ Eczema ☐ Psoriasis
☐ Recent moles ☐ Liver spots ☐ Poor healing sores ☐ Easily bleeding ☐ Poorly healing wounds
☐ Dry hair ☐ Oily hair ☐ Thinning / weak hair ☐ Dandruff ☐ Hair loss ☐ Scalp itching ☐ Brittle nails
☐ Ridges on nails ☐ White spots on nails ☐ Clubbing of nails
☐ Other _____

**Urinary (Mutravaha Srotas, Shukra Dhatu)**

☐ Painful or burning urination ☐ Frequent urination ☐ Urgency of urination ☐ Urinary incontinance
☐ Dribbling at the end of urination ☐ Blood in urine ☐ Cloudy urine ☐ Frequent Urinary Tract Infections
☐ Kidney / bladder stones ☐ Water retention / Edema; if yes, where? _____
☐ Other _____

**Male-Reproductive**

☐ Prostate enlargement ☐ Testicular pain, discomfort, swelling ☐ Other inguinal pain or discomfort
☐ Erectile dysfunction ☐ Premature ejaculation ☐ Low libido
☐ Other _____

**Female-Reproductive**

☐ Vaginal discharge, if yes what is the color and consistency? _____ ☐ Vaginal itching
☐ Ovarian cysts ☐ Uterine fibroids ☐ Fibrocystic breasts ☐ Anemia ☐ Pain with intercourse
☐ Do you menstruate? _____ ☐ What age did you have your first period (menarche)? _____
☐ Length of your cycle (period to period)? _____ ☐ Duration of bleeding? _____
☐ Light, normal, or heavy? _____

Do you have premenstrual symptoms (PMS)? Check if applicable:

☐ Anxiety ☐ Mood swings ☐ Depression ☐ Craving sweets ☐ Dizziness ☐ Headaches
☐ Insomnia ☐ Increased appetite ☐ Decreased appetite ☐ Abdominal bloating ☐ Diarrhea
☐ Constipation ☐ Fatigue ☐ Breast tenderness ☐ Water retention ☐ Lower back pain

How many pregnancies have you had? _____ Births? _____ Miscarriages? _____ Abortions? _____
Do you use contraceptives? _____ If so, which ones? _____
Are you post-menopausal? _____ If yes, when was the approximate date of your last period? _____
If you have menopausal symptoms, please describe your major symptoms.

Other gynecological issues?

Thank You For
Taking The Time

## Legal Disclaimer

Services offered at **Ulli Ayurveda** are not intended to diagnose or treat any disease, nor are they an alternative to the treatment prescribed by your doctor. If you have a medical diagnosis or you suspect you may have a serious medical condition, you should see a specialist for the appropriate medical intervention. The nutritional, lifestyle and herbal consultations offered at my center are intended for providing information and recommendation only. They are not a prescription, or otherwise obligatory.

I, the undersigned, hereby confirm that I have read, understood and agreed to the above statement, and that I am consulting with practitioners at **Ulli Ayurveda** of my own free will.

Signature _____ Date _____

Print Name _____