Ayurvedic Holistic Health Analysis Questionnaire

Date:.....Name.....Signature.....

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ In-Relationship

Age:.....Height: .....Weight: Past…… Current…… Occupation: .....

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

Address: ..... City:…….State..... Zip .....

Phone: ..... e-mail :.....

Why are you interested in an Ayurvedic consultation?……

How did you hear about us? .....

Please describe your present health concerns and their <u>duration</u>?

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 ☐ Some what ☐ 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 ☐ Several 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:

Type of Medicines	Past	Present
Prescription Medicines		
Over the counter Medicines		
Herbs / Vitamins		

Do you experience any of the following symptoms in various seasons?

WINTER	SUMMER	SPRING
❑ Attention Deficit	❑ Acne	❑ Asthma
❑ Anxiety	❑ Anger	❑ Apathy
❑ Constipation	❑ Boils	❑ Bronchitis
❑ Dry / rough skin	❑ Burning in the eyes	❑ Depression
❑ Depression	❑ Diarrhea	❑ Difficulty paying attention
❑ Fatigue	❑ Excessive body heat	❑ Nasal allergies
❑ Headache	❑ Excessive competition	❑ Neediness
❑ Hyperactivity	❑ Excessive Hunger	❑ Oily skin
❑ Insomnia	❑ Frustration	❑ Overweight
❑ Intolerance to cold	❑ Hostility	❑ Slow digestion
❑ Restlessness	❑ Inflammation of skin	❑ Sinus congestion
❑ Stomachaches	❑ Irritability	❑ Spaceyness
❑ Underweight / weight loss	❑ Rashes	❑ Skin growths
❑ Worry	❑ Visual problems	❑ Possessiveness
Total	**Total**	**Total**

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

Concern	Father	Mother	Brothers	Sisters	Spouse	Child	Other
Age (if living)							
Age (at death)							
Cause of death							
Anemia							
Cancer							
Diabetes							
Epilepsy							
Glaucoma							
Heart disease							
High blood pressure							
Hay fever							
Hives							
Kidney disease							
Mental disease							
Rheumatic arthritis							
Tuberculosis							
Syphilis							
Stroke							
Others							

Do you have any past medical history? If yes, please specify the age of occurrence, duration and its treatment.

Please indicate if you have ever had any of the following:

Disease	Past	Present
Measles		
Migraine		
Arthritis		
Rheumatism		
Bone disease		
Joint Disease		
Alcoholism		
Neuritis		
Thyroid disease		
Other headaches		
Meningitis		
Tension		
Anxiety		
Depression		
Drug Abuse		
Nervous breakdown		
Venereal disease		
Cancer		
Anemia		
High Blood pressure		
Hay Fever		
Poison ivy / oak		
Rheumatic fever		
Scarlet fever		
Childhood hyperactivity		
Genetic disease		
Tuberculosis		
Skin disorders		
Liver disorders		
Stroke		
Blood disease		

Yellow Jaundice		
Asthma		
Chickenpox		
Polio		
Diphtheria		
Smallpox		
Diverticulosis		
Hemorrhoids		
Hernia		
Kidney disease		
Kidney stones		
Gallbladder stones		
Chronic sinusitis		
Broken bones		
Concussion		
Nasal Allergies		
Skin Allergies		
Bronchitis		
Mumps		
Emphysema		
Pneumonia		
Pancreatitis		
Ulcers		
Bursitis		
Sciatica		
Low back pain		
Diabetes		
Heart Trouble		
Head Injury		
Malaria		
Others		

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?

Do you have any type of Pets? ☐ Yes ☐ No
If Yes, Please specify ……

Health as a child: ☐ Good ☐ Fair ☐ Poor

Childhood illnesses:
☐ Scarlet Fever ☐ German measles ☐ Measles ☐ Mumps
☐ Bronchial problems ☐ Rheumatic fever ☐ Diphtheria ☐ Other ……

Immunizations / Vaccinations:
☐ Smallpox ☐ Polio ☐ Typhoid ☐ Mumps☐ Tetanus ☐ Influenza ☐ Others …….

Any Vaccination Reaction:……..

Do you use any of the following?
☐ Microwave Cooking ☐ Electric Blanket ☐ Aluminum Cookware ☐ Hair dye

Do you have Mercury fillings (Amalgams)?
☐ Yes ☐ No, if yes, please explain since how long ……..

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 daytime ☐ Immediately after meals
☐ Immediately after dinner ☐ Need laxative daily ☐ Other, please specify .....

Bowel nature: ☐ Soft ☐ Medium ☐ Hard

Bowel movement associated with: ☐ Pain ☐ Gas ☐ Blood ☐ Mucous ☐ Foul smell
☐ Other ……..

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 ☐ Others ……

Do you delay or suppress any of the following?
☐ Bowel movements ☐ Gas ☐ Urination ☐ Sleep ☐ Yawning ☐ Burping
☐ Breathing ☐ Sneezing ☐ Hunger ☐ Thirst ☐ Semen ☐ Cry, tears

Do you practice any type of meditation? Please explain.

Do you practice any Yoga techniques? Please explain.

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
☐ Suicidal tendency ☐ Anger ☐ Irritation

Do you get up early? ☐ Yes ☐ No At what time.....

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

Do you sleep in the daytime? ☐ Yes ☐ No

How do you generally feel on arising in the morning?
☐ Fresh and rested ☐ 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

To what direction does your head point during sleep?
☐ East ☐ West ☐ North ☐ South
☐ Northeast ☐ Northwest ☐ Southwest ☐ Southeast

What is your sleeping position?
☐ On back ☐ On 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?)
☐ Very regular ☐ Some what 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

How often do you exercise?
☐ Weekly once ☐ Weekly twice ☐ Weekly thrice ☐ Weekly four times ☐ Every day ☐ Not at all

How long do you exercise? .....What type of exercise? ……

Is your exercise: (choose one) ☐ Vigorous ☐ Moderate ☐ Light Type of exercise:.....

Do you smoke cigarettes or others? ☐ Yes ☐ No
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:.....

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

Which type of weather makes you feel most uncomfortable? (Choose one) ☐ Cold ☐ Hot ☐ Cool and damp

DO YOU EAT THE FOLLOWING FOOD GROUPS

Food groups	Daily	Weekly	Monthly	Never
Grains / Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

Please explain your typical food habit?
Breakfast: .....

Lunch: .....

Dinner: .....

Snacks: .....

Do you eat between meals? ☐ Yes ☐ No

Do you eat your meals on time? ☐ Yes ☐ No

Which is your main meal? ☐ Breakfast ☐ Lunch ☐ Dinner

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 ☐ Eat regular times
☐ Talk or converse a lot while eating ☐ Eat very fast
☐ Watch television while eating ☐ Never sit to eat ☐ Never on time

Describe your diet: ☐ Vegan ☐ Lacto-vegetarian ☐ Ova-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 or crave?
☐ Sweet ☐ Salty ☐ Bitter ☐ Sour ☐ Hot/Spicy ☐ Starches ☐ Oily

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

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

As a child, did you experience any abuse or trauma? ☐ None ☐ Emotional ☐ Physical
☐ Sexual ☐ Verbal ☐ Other, please explain .....

For Men only:
Do you have any problems?
☐ Hernias ☐ Testicular masses ☐ Sexually active ☐ Sexual difficulties
☐ Prostate problems ☐ Venereal disease ☐ Discharge or sores ☐ Libido
☐ Problem starting urination ☐ Problem stopping urination ☐ Erection problems
☐ Birth control ☐ Tenderness, enlargement of breast

For Women only:
Age menses began: ……..
Which of the following describes your menstruation? (You may choose more than one)
☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased due to menopause

How many 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 explain.....

How is your menstrual flow? ☐ Heavy ☐ Light ☐ Normal ☐ Abnormal vaginal discharges

Associated symptoms (before or during menstruation):
☐ None ☐ Pain ☐ Fluid retention ☐ Migraine ☐ Depression
☐ Acne ☐ Tension ☐ Anger ☐ Frustration ☐ Loneliness
☐ Nightmares ☐Suicidal tendency ☐ Other, please specify .....

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

Do you experience pain during intercourse? ☐ Yes ☐ No

Do you have any sexual difficulties? ☐ Yes ☐ No
If yes, please explain ……

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

Do you take contraceptive pills or other devices? ☐ Yes ☐ No If yes, Please explain……

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? ..... Children's ages:
.....……

Do you self-exam breasts regularly? ……

Do you experience any problems in breasts? ☐ Lumps ☐ Pain or tenderness ☐ Nipple discharge ☐ Others ……

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.
( ) 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 have cold, variable sexuality.
( ) 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 energy tends to come in bursts.
( ) My moods change easily, and I am somewhat emotional by nature.
( ) My characteristic gait (walk) while walking is light and quick.

Total Vata Score: _____

Pitta Personality

( ) I consider myself to be very effective in my work and activities.
( ) I have medium, proportionate, toned body frame.
( ) 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.
( ) I have hot intense sexuality.
( ) One or more of these 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.
( ) My body frame is heavy, broad, evenly proportioned.
( ) 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 work well with good routine.
( ) I generally eat slowly and my activities are methodical.
( ) I dislike cool and damp weather, and it bothers me a lot.
( ) I have warm, enduring sexuality
( ) 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 _____

Questionnaire Regarding Level of Your Mind - Body Impurities

Please circle that the following statements apply to you

Signs & Symptoms	None	Mild	Moderate	Severe
I generally feel constipated.	0	1	2	3
I often get congestion in my head and sinuses	0	1	2	3
I often get infections.	0	1	2	3
I feel my immune system is weak	0	1	2	3
I feel non-clarity of mind	0	1	2	3
I feel physically exhausted without any reason	0	1	2	3
I feel mentally exhausted easily	0	1	2	3
My stress levels are	0	1	2	3
I have no desire to eat food	0	1	2	3
I tend to feel indigestion frequently	0	1	2	3
I tend to get lot of salivation in the mouth	0	1	2	3
I easily get angry and irritated without any real reason	0	1	2	3
I feel that my breathing pattern altered	0	1	2	3
I frequently get cold throughout the year	0	1	2	3
I tend to get allergies throughout the year	0	1	2	3
I feel heaviness in the body	0	1	2	3
I feel something is not well in my mind-body	0	1	2	3
Total				

1 to 17 = Mild 17 to 34 = Moderate 35 to 51 = Severe

Questionnaire Regarding Indigestion

Please circle that the following statements apply to you

0 = Not applicable 1 = Mild 2 = Moderate 3 = Severe

Abdominal pain	0	1	2	3
Anorexia	0	1	2	3
Body aches	0	1	2	3
Fainting	0	1	2	3
Fever	0	1	2	3
Flatulence	0	1	2	3
Giddiness / dizziness	0	1	2	3
Gripping pain / colic	0	1	2	3
Headache	0	1	2	3

Heaviness in abdomen	0	1	2	3
Improper digestion of food	0	1	2	3
Malaise (Body aches)	0	1	2	3
Slow digestion	0	1	2	3
Stiffness in back & waist	0	1	2	3
Thirst	0	1	2	3
Vomiting	0	1	2	3
Yawning	0	1	2	3
TOTAL				

1 to 17 = Mild 17 to 34 = Moderate 35 to 51 = Severe

Questionnaire Regarding Parasites

0 = Not applicable 1 = Mild 2 = Moderate 3 = Severe

Feeling tired most the time (Chronic fatigue)	0	1	2	3
Digestive problems (gas, bloating, constipation or diarrhea)	0	1	2	3
Gastrointestinal symptoms and bulky stools with excess fat in feces	0	1	2	3
Food sensitivities and environmental intolerance	0	1	2	3
Allergic-like reactions	0	1	2	3
Joint and muscle pains and inflammation	0	1	2	3
Anemia or iron deficiency	0	1	2	3
Hives, rashes, weeping eczema, cutaneous ulcers, swelling, sores, papular lesions, itchy dermattis	0	1	2	3
Restlessness and anxiety	0	1	2	3
Multiple awakenings during the night and teeth grinding	0	1	2	3
Excessive amounts of bacterial or viral infections	0	1	2	3
Depression	0	1	2	3
Difficulty gaining or losing weight	0	1	2	3
TOTAL				

1 to 13 = Mild
14 to 26 = Moderate
27 to 39 = Severe