Client Health Questionnaire Please answer all questions thoroughly and honestly

Date of Initial Visit:_____

Client Contact & Personal Information (PLEASE PRINT LEGIBLY- ALL Fields ARE REQUIRED)

Name: _____ Email: _____

Address: _____

City:_____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Married:____ Divorced:____Single:_____ In a partnership/relationship:____ How long? _____

Emergency Contact:_____ Emergency Contact Phone#_____

How did you hear about us? _____

Date of Birth: _____ Your Age: _____

Use **DD-MMM-YYYY format e.g. 14-JUN-2014**

Please complete to the best of your ability:

Briefly describe the problem(s) for which you seek help. Please include the dates when each problem occurred, and how long you have been experiencing the problem: _____

_____

_____

_____

Please list past medical history (injuries, accidents, surgeries, illnesses, conditions) including approximate dates.

List all medications & supplements that you are taking, and the condition you are taking them for:

What daily activities are you finding difficult or are limited because of your above complaints?

What are your goals for this visit? (include physical or emotional wellbeing goals)

Please list any other kind of health care professional you are seeing/have seen for this/these problem(s):

Please check any symptoms that you are experiencing now:

Digestion:

___Poor Digestion ___Poor appetite ___ Excessive appetite ___ Crave Sugar ___Gall Stones? ___ Ulcers? ___ Loose stools/diarrhea ___ Constipation ___ Nausea/vomiting ___ Heartburn ___Acid reflux ___Difficulty digesting fats ___Gas or belching ___Stomach/ intestinal pain/ cramping ____ IBS / IBD?_____ (Any Medical Diagnosis?)

___rectal pain when going to the bathroom ___ Bloating ___ Blood in stool ___ Mucus in the stool

____# of Bowel movements per day ___ Urgency? ___ Hemorrhoids ___Other:_____ Food

Allergies:_____

Respiratory: Do you smoke cigarettes now?____ How many do you smoke? _____ Smoked in the past? How much and how long? _____Do you smoke marijuana or other drugs? ____ How much? ____

___Allergies ____Catch colds easily _____Sinus problems _____ Congestion nasal or chest

___ Asthma ____Shortness of breath ___Dry cough ___Wet cough ___ Wheezing ___ Chest tightness

___ Nose bleeds ____ Other: _____

Circulation/Cardiovascular:___High blood pressure ____Slow heart rate ___ Irregular heart beat ___Fast heart rate ___ Palpitations ___Too hot ____ Too cold____Dizziness ___Low blood pressure ____Chest pain ___ Water retention ___ Cold hands/feet ____Other:_____

Urinary: ___Painful urination___Incontinence___Difficulty urinating __Kidney stones ___Kidney infections

___Urinary tract infections _____Other:_____

Other:____ Difficulty learning ___ Difficulty paying attention __Difficulty with speech _____Difficulty walking __Muscle weakness ___Numb/tingling. Where?_____ ___Poor coordination ___Shaky ____Fatigue

__Loss of balance ___ Thirsty ____No thirst ____Poor sense of taste ___poor sense of smell __ Dry mouth ___Dry eyes ___Watery eyes ___ Poor vision ___ Eye pain___ Other eye problems?

___Headaches ___ Migraines ___Poor hearing ___ Ringing in ears ___Development/growth issues ___Difficulty swallowing ___ Anemia __ Eczema / Psoriasis or Dermatitis _ ____Skin condition ___Joint swelling ____Nose bleeds
____Insomnia __Lots of sleep. ___ No. of hours per day ? ____ Do you feel rested? ___Take sleep aids? ____Nightmares

<u>Women Only:</u>

____Breast pain /tenderness ___ Are your cycles regular? ____Length of cycle: ___Painful menses

___Heavy or excessive flow ___PMS _____Uterine Fibroids___ Breast Fibroids

_____Other:_____

_____

____ No. of Pregnancies ____ Miscarriages/Abortions ___ Pregnant now? ____ Want to be pregnant?

____ Chemical or physical contraception? ____ Painful intercourse ____ Vaginal Dryness

Wellbeing and Emotional Stress Questionnaire

a: Please **circle** anything that you may have experienced in the past few months.:

Emotional Despair Helpless Uneasy Distress Fearful Angry Panic Guilty Sad Paranoid

Muddled Grief Nervous Worried Restless Criticized Rejected Agitated Impatient Apprehensive

Overwhelmed Intimidated Depressed Easily Irritated Unable to Grieve Overworked Persecuted

Aggravated Uncertainty Annoyed Outraged Obsessive Indecisive Intolerant Paralyzed

Hopeless Anxious Abused

b: Please **check** your level of stress from the listings below.

Family stress is:◯None◯Minimal◯Moderate◯Severe

Relationship stress is:◯None◯Minimal◯Moderate◯Severe

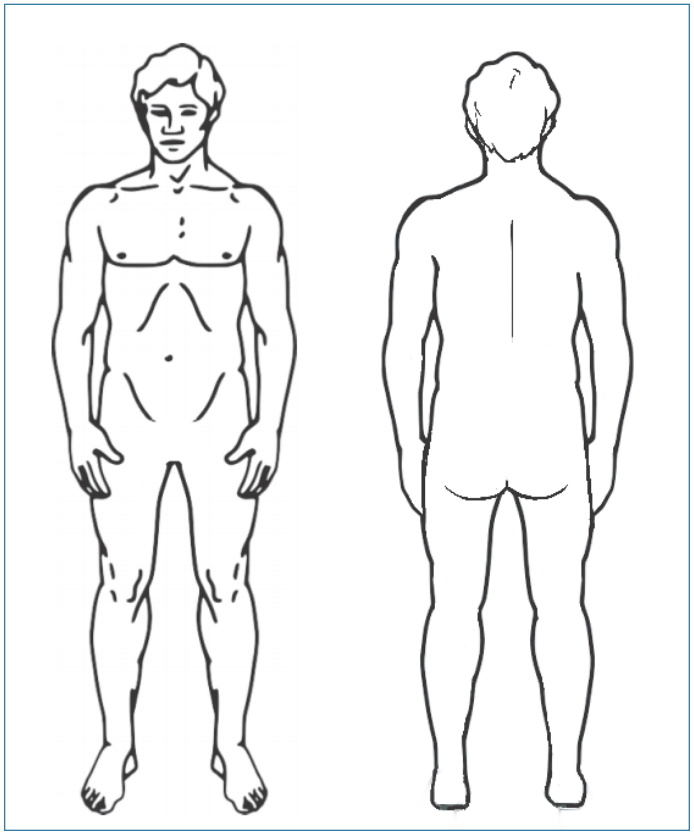
Work stress is:◯None◯Minimal◯Moderate◯Severe

Financial stress is:◯None◯Minimal◯Moderate◯Severe

Health stress is:◯None◯Minimal◯Moderate◯Severe

Other stress is: _____◯None◯Minimal◯

c: Please **mark** areas of pain/discomfort on the diagrams below. Include comments on the side if necessary



Client Signature:_____

Date Signed: _____

Consent/ Disclaimer /Financial Responsibility

Today's Date:_____ Client Full Name (PRINT) :_____

I understand that **Ayurveda** is a traditional holistic system of addressing health through self-awareness to promote the proper balance between mind, body, and consciousness. It emphasizes the importance of creating and maintaining a balanced internal and external environment conducive to positive health. Through proper lifestyle, diet, exercise, herbs, cleansing regimes, and rejuvenation programs, Ayurveda has traditionally helped one lead a balanced life.
The practitioner may evaluate and assess my current state of health by examining my physiology and structure, movement and other functioning visually or by touch or by asking questions.

[Client Signature:_____]

I understand that **BodyTalk** is an energy medicine/alternative complementary medicine system. BodyTalk sessions are safe, non-invasive and objective. It work at the subtler levels of physiology balancing the body-mind complex in relationship to each other. BodyTalk sessions are intended to enhance relaxation, increase communication within the areas of the body, and to educate the client to possible energetic or emotional blocks that may create pain and disease. It utilizes the body's own innate intelligence to reestablish communication within itself. The Practitioner maintains physical touch with the client's arm to establish a neuromuscular bio-feedback monitoring system throughout the client session. If the client has any objections to the practitioner physically touching the client, sessions may be done without physical contact as well and tapping is done off the body. It is the responsibility of the client to notify the practitioner in advance of any objections regarding this protocol or procedure followed.

Client Signature:_____

I understand that BodyTalk sessions are not a substitute for medical treatment or medications. I am aware that the BodyTalk Practitioner does not diagnose illness or disease nor does the Practitioner prescribe or test for medications or supplements.
[Client full Signature: _____]

I understand that Gayathri Shylesh offers Ayurvedic consultations that may include dietary guidelines and lifestyle, or stress management guidelines and that she is not a licensed medical practitioner.
[Client Initials:_____]

I understand and agree that any Ayurvedic consultation with Gayathri Shylesh are for recommendations for a balancing program which is strictly educational and are not intended as, or in replacement of any medical services or my primary health care practitioner and their treatment.
[Client Initials:_____]

The recommendations made are intended as balancing and harmonizing to the physiology and are not intended as treatments for specific medical disorders. No attempt will be made to diagnose, treat, cure, or prevent any medical or psychological ailment, no medical prescriptions will be offered. I understand that Gayathri Shylesh will **not** test or evaluate any current prescriptions or supplements or its efficacy or effectiveness.

[Client Initials:_____]

I understand and agree that Gayathri Shylesh is not conducting a medical examination for me. I will continue to seek the advice of my primary health care practitioner and any other medical specialist with whom I have consulted previously. Additionally, I will not modify or suspend any ongoing or new treatment protocols or programs that I am now receiving, based upon the recommendations provided.

[Client Initials:_____]

BodyTalk sessions and Ayurvedic regimens are currently not considered as a medical protocol for treatment and are considered as Complementary Medicine modalities which are not viewed as mainstream medical system for health and wellbeing. I understand that my health records are confidential and will not be shared or discussed with anyone else. My treatment session notes and records may not be subpoenaed or used in a court of law for any accident claims or liability claims. I understand that I will receive a copy of my session notes if I request this explicitly. I may use these notes as records if I choose to provide this in a court of law for any litigation cases.

[Client Initials:_____]

I understand that BodyTalk sessions and Ayurvedic regimens are not covered by traditional medical insurance and that I will assume **all** responsibility for payment of the consultation and any supplemental items or services purchased at the time of service. Any claim forms for reimbursements from insurance or other medical coverage plans will be completed by me.

[Client Initials:_____]

Furthermore, any payments made for services provided are due at the time of service or may be prepaid in advance of your session. I understand that Gayathri Shylesh will not issue receipt for payments made, unless explicitly requested. Gayathri will also be unable to provide billing records or payment history to be used in a court of law. It is my responsibility as a client to maintain a record of payments made to this practitioner.

[Client Initials:_____]