

THE AYURVEDIC CENTER OF VERMONT, LLC

Health Information and History

Name _____ DOB _____ Date _____

Age _____ Occupation _____ Email Address _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Referred By _____ Physician _____ Physician Phone _____

Please list your health objectives/goals regarding this consultation and/or treatment:

Personal History:
Concerns: Please list your health concerns. How long have they troubled you?

Please describe any other conditions that are currently bothering you, such as: Aches, pains, degenerative illnesses, stress, fatigue, constipation, high blood pressure, high cholesterol, energy levels, mental clarity, concentration, vision, fever, hot flashes, chills, insomnia, nervousness, or other conditions that you can think of:

Are you under a physician's care now? _____ Why? _____

Are you taking any prescription drugs or medications? _____

What surgeries have you had? _____ When? _____

Last physical examination (date)? _____ Height _____ Weight _____
Cholesterol _____ Blood Pressure _____

Do you or your parents, brothers or sisters have history of:
(Please put an "X" in the appropriate column.)

	<u>Myself</u>	<u>Family Member</u>
Allergies to Food or Drugs		
Cancer		
Chemotherapy/Radiation Treatment		
Heart Disease/Heart Murmur		
Arthritis		
Heart Attack/Heart Surgery		
Chest Pain		
Shortness of Breath		
Swelling of Feet or ankles		
Stroke		
High or Low Blood Pressure		
Prolonged bleeding when cut		
Asthma, Pneumonia, TB		
Anemia		
Mononucleosis, Hepatitis, Jaundice, Gallstone		
Diabetes		
Fainting, Dizziness		
Ulcers, Intestinal Bleeding		
Hemorrhoids		
	<u>Myself</u>	<u>Family Member</u>
Kidney or Bladder disease		

HIV exposure

Epilepsy, Convulsions, Seizures

Thyroid Disease or Medication

Glaucoma, Eye surgery

Contact Lenses

Implants, Prosthesis

Pain or Ringing in the Ears

Ear infections or any kind of problems

Popping, clicking or locking of the Jaw

Psychiatric Treatment

Venereal Diseases

Complicated Dental Treatment

Please list any other disease or problems not listed above?

If female, are you pregnant? _____

Taking birth control pills? _____

Last menstrual cycle? _____

I acknowledge that this consultation is for educational purposes, that this is not a substitute for medical care and diagnosis and I take full responsibility for my health.

Client Signature

Date