

**Life In Balance**  
**Ayurvedic Rejuvenation Center**  
**CONFIDENTIAL CLIENT HISTORY**

Client's Name: _____		
Client's Address: _____		
City, State, Zip: _____		
Telephone—Home: _____	Work: _____	E-mail: _____
Birth date: _____	Birth place: _____	Age: _____
Time of birth: _____	Place of childhood: _____	
Marital/partner status: _____	# of children: _____	Ages: _____
Occupation: _____	Blood type: _____	Height: _____ Weight: _____
How did you hear about Life in Balance? : _____		

**FINANCIAL POLICY AGREEMENT**

1. The Center does not bill insurance companies for services.
2. Panchakarma services may be recommended and provided at the Center. Half of payment for those services is due to the Center when the appointments are scheduled.
3. If you miss an appointment with your clinician without giving 24 hours notice, a \$25 fee is charged to your account.

I have read and understood the financial policies of Life In Balance Rejuvenation Center.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **LIFE IN BALANCE**

## **Ayurvedic Rejuvenation Center**

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1. *Intention of Program: To educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. As you begin to move towards balance, you become more conscious and your natural, innate intelligence wakes-up, you begin to naturally make choices that are nurturing, healing, and balancing. You will be educated and empowered to take charge of your own health, and begin to develop the awareness to bring balance and health to each moment of your life, restoring you to your true joyful nature and present to the beauty and magic of life.*
  
  2. *Outline of Services: 1 1/2 hour Consultation; an opportunity to assess your current physical, mental and spiritual routines, your prakruti (fundamental state of balance) and your vikruti (current imbalance). I will begin to educate you on your individual constitution and the basics of Ayurveda. You will be introduced to new practices as part of your plan for achieving balance. Practices may include meditation, yoga, dietary adjustments and breathing exercises all designed to further your education, awareness and ability to bring balance to your life. Periodic 45 min. follow-up sessions will be recommended to monitor and support your progress. In this way you can integrate lifestyle changes over time and we can make any adjustments needed in your program.*
  
  3. *Ayurveda is not about instantaneous results, although you will see many immediate benefits. In accordance with the laws of nature, it will take time to gently restore full balance. Life is dynamic and we are part of life. We continually need to modify our lifestyle to the changing seasons, emotions, stresses etc. to achieve balance. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living. Using the ancient wisdom of Ayurveda I will educate, empower and support you as a dynamic individual, but it is up to you to bring this into your daily life. It is a simple, natural science that takes time, as it takes time for the stream to wear the stone smooth, but gently, over time it changes form completely. It is amazing the difference a small adjustment in your diet or lifestyle can make to create greater well-being. I am excited and honored to assist you in discovering your uniqueness and create a balanced life with radiant health and a peaceful mind.*
  
  4. *Requirement of Client:*
    - A. *24-Hour Cancellation Notice. Less than 24 hours notice will require a \$25.00 rescheduling fee.*
    - B. *Payment of Ayurvedic Consultation is \$185.00. Payment is expected in full during our initial Ayurvedic Consultation.*

Client Signature: \_\_\_\_\_

Ayurvedic Practitioner: \_\_\_\_\_

***Please take quiet time and space to answer these questions. Take this as an opportunity to bring awareness to areas of your life that may need more loving attention. Use a separate sheet of paper if needed.***

1. *What are you currently doing in your life that brings you peace, health, balance and/or nurtures your soul?*
  
2. *What would you like to get out of the Ayurvedic Consultation?*
  - a)
  
  - b)
  
  - c)
  
2. *Where in your health, life, and relationships (to self and others) do you experience a lack of freedom, balance, and joy?*
  
3. *Which areas in your life are you most interested in bringing balance to?*
  
4. *If you achieved a perfect state of health, which is balance between your fundamental energies, or “doshas” and your body, mind and soul or consciousness, what would your life look like? How would you feel? What would you be doing? What would be different? Paint a picture for yourself.*
  
5. *What results do you want to produce in your physical body?*
  
6. *What results do you want to produce in regards to your mental and emotional well-being? Do you find yourself anxious, stressed, depressed, or easily brought to annoyance or anger?*

7. *What do you want your spiritual life to look like?*
  
8. *How can I best support you in achieving the health, vitality, and balance you want in your life?*
  
9. *What would you have to give up to have the results you want?*
  
10. *Where do you go, what does it look like when you get resigned or go down the deep dark tunnel of despair?*

## **INFORMED CONSENT**

*to receive Alternative Health Care through the  
**Life In Balance Rejuvenation Center***

*All clients who participate in Ayurvedic health care should be advised of the following:*

- 1. The goal of all programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself using the principles of Ayurveda. Our mission is to empower and educate people to create and take charge of their own health, such that you are energized, joyful and present to the beauty and magic of life.*
- 2. The Life In Balance Rejuvenation Center is not a primary care medical clinic.*
- 3. Not all our clinicians are trained in Western medical diagnosis or treatments.*
- 4. If you are suffering from a disease or symptom that has not been evaluated by a medical doctor or another licensed health care professional, you must be evaluated by a medical doctor. If you choose not to see a medical doctor, you will have to sign an acknowledgment that one was recommended to you.*
- 5. I give permission for the Rejuvenation Center to use the information in my chart for research purposes. (Any publication of our research will not include patient names.)*

*I have read and understand the above information.*

*Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_*

## CHIEF HEALTH CONCERNS

What are your main health concerns at this time? Order by importance to client.

PRIMARY CONCERNS	CLINICIAN NOTES
1.	
2.	
3.	
4.	
5.	
6.	

## PAST MEDICAL HISTORY

Include major conditions, dates of treatment and procedures performed.

1. Serious illnesses: \_\_\_\_\_

\_\_\_\_\_

2. Hospitalizations: \_\_\_\_\_

3. Operations: \_\_\_\_\_

4. List other pertinent past conditions: \_\_\_\_\_

\_\_\_\_\_

5. Have you been under the care of a licensed health care professional in the past year?  Yes  No

If so, for what reasons: \_\_\_\_\_

6. Is there any possibility that you are pregnant?  Y  N

## FAMILY HISTORY PLEASE CHECK THE APPROPRIATE BOXES AND INDICATE FAMILY MEMBER.

Cancer

Diabetes

High Blood Pressure

Heart Disease

Stroke

Mental Disorder

Other (explain)

Other (explain)

## **CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS**

*What medications, herbs, supplements are you currently taking?  
Please include significant remedies that you have recently stopped taking.*

<b>Name of substance:</b> _____
<input type="checkbox"/> <i>Prescription</i> <input type="checkbox"/> <i>over-the-counter</i> <input type="checkbox"/> <i>herbal</i> <input type="checkbox"/> <i>vitamin</i> <input type="checkbox"/> <i>other</i>
Who recommended/prescribed it? _____
Purpose of substance: _____
How long have you been taking it: _____
In what form do you take it (include dosage): _____
How often do you take it? _____
What effects have you noticed? _____

<b>Name of substance:</b> _____
<input type="checkbox"/> <i>Prescription</i> <input type="checkbox"/> <i>over-the-counter</i> <input type="checkbox"/> <i>herbal</i> <input type="checkbox"/> <i>vitamin</i> <input type="checkbox"/> <i>other</i>
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Purpose of substance: _____
How long have you been taking it: _____
In what form do you take it (include dosage): _____
How often do you take it? _____
What effects have you noticed? _____

## DAILY ROUTINES

To be filled out by client

**DAILY SCHEDULE** (include approximate times)

1. Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities).

	Time	Activities	
Morning			VARIATIONS
Awaken			
Breakfast			
Activities			
Mid-day			
Lunch			
Activities			
Evening			
Supper			
Activities			
Night			
Activities			
Bed-time			

2. List regular practices that are not included in the above schedule, e.g., exercise, meditation, spiritual practices, etc.

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3. Are you sexually active? Y  N  Frequency?

4. Other comments about daily routines:

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5. What types of food(s) are eaten on a regular basis?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

6. Are there any routines around eating:

7. Any current or past problems with chronic eating disorders or other food related issues?  Y  N

**ALLERGIES OR SENSITIVITIES**

8. Do you have allergic reactions to any substances? If yes, please list.

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**GENERAL HEALTH HABITS**

9. How many cups of caffeinated beverages do you drink per day?

# \_\_\_\_\_ Type(s) of beverage: coffee/tea/soda

10. How many cups of non-caffeinated beverages do you drink per day? # \_\_\_\_\_

Type(s) of beverage: herbal tea/milk/juice/other \_\_\_\_\_

11. How much water do you drink per day? \_\_\_\_\_

12. Do you exercise regularly?  Y  N Length of time: \_\_\_\_\_

Times per week: \_\_\_\_\_ Type(s) of exercise: \_\_\_\_\_

13. If you smoke, how many cigarettes do you smoke per day? \_\_\_\_\_ Have you ever smoked?  Y  N

Amount/day: \_\_\_\_\_ When quit? \_\_\_\_\_

14. If you drink alcohol, how many glasses of alcohol per week? (Include beer, wine, liqueurs and hard liquor) # \_\_\_\_\_ per week Type(s) of beverage: \_\_\_\_\_

15. Any current or past problems with addiction or substance abuse?  Y  N

Substance: \_\_\_\_\_ Amount: \_\_\_\_\_ When quit? \_\_\_\_\_

16. Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite): \_\_\_\_\_

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17. Body temperature: Do you generally run warm or cold? Please explain: \_\_\_\_\_

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## REVIEW OF SYMPTOMS

*Check all symptoms that are of concern to you at this time that you want to discuss with the practitioner. Please indicate any area in which you have experienced a severe episode and indicate if episode was in previous 6 months or prior to 6 months time.*

Concern	Office	
		<b>HEAD</b>
		Headaches
		Dizziness
		Fainting spells
		Loss of balance
		Difficulty remembering
		Difficulty thinking clearly
		Thinning or loss of hair

Concern	Office	
		<b>MOUTH</b>
		Excessive thirst
		Loss of taste
		Strange taste
		Bad breath
		Lip ulcers or lesions
		Dry/cracking lips
		Tongue pain
		Bleeding gums
		Receding gums
		Tooth pain
		TMJ

Concern	Office	
		<b>EARS</b>
		Hearing loss
		Ringing
		Earaches–Pain
		Discharges
		Bleeding

Concern	Office	
		<b>NECK</b>
		Pain
		Swollen glands
		Lumps
		Stiffness

Concern	Office	
		<b>EYES</b>
		Pain–soreness in eyes
		Redness
		Burning
		Mucous
		Dryness
		Itching
		Tic/twitch
		Blurred/loss of vision

Concern	Office	
		<b>CHEST</b>
		Pain in chest
		Tightness/pressure in chest
		Heart palpitations
		Shortness of breath
		Painful–difficult breathing
		Persistent cough
		Frequent chest colds

Concern	Office	
		<b>NOSE</b>
		Loss of smell
		Bleeding
		Pain

Concern	Office	
		<b>SKIN</b>
		Dry–flakey
		Rashes
		Blisters




Pain/ache in joints  
 Stiff joints  
 Persistent muscle/bone pains  
 Tremors/tics in muscles  
 Muscle weakness/atrophy


Tenderness–pain

Concern Office

**MALE SYSTEM**


Prostate gland swollen/painful  
 Low sperm count  
 Low motility  
 Genital sores or lesions  
 Genital discharge  
 Erection difficulty

Concern Office

**NERVES**


Loss of taste, smell or touch  
 Tingling sensations  
 Tremors in limbs  
 Uncoordinated muscle/limbs