LIFE'S A GIFT

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CHARMAINE VAN NIEKERK
Ayurvedic Health Practitioner

Appointment Date & Time:_____ *Please write neatly in black ink only*

Name:_____

Address:_____

City, State, Zip:_____

Telephone—Home:_____Cell:_____E-mail:_____

Birthdate:_____Age:_____Height:_____Weight:_____

Marital/partner status:_____# of children:_____Ages:_____

Occupation:_____

Emergency contact name and number:_____

How did you hear about *Life's a Gift*? _____

Please tell us why you have chosen to have an Ayurvedic Consultation: _____

_____

CHIEF COMPLAINTS:

Describe the course of the symptoms from the beginning to the present time. Is there any factor that you feel contributed significantly to your illness?

Complaint/Symptom	When it started & duration	Any other comments

FOR Practitioner USE ONLY:

Initial Appointment:_______________

IO Date:_______________ CM Date:______________ ROF Date:______________

WHAT YOU CAN EXPECT FROM YOUR AYURVEDIC HEALTH CARE

We start by listening closely to how you are experiencing disease or un-wellness in your life, your symptoms and long-term patterns, as well as personal goals and desires. All the factors that affect your health and the quality of your life are evaluated in great detail, including your food habits, quality of digestion, sleep patterns, lifestyle, and stressors. This information is captured in a clinical questionnaire that covers your detailed medical history, symptoms and long-term patterns, and along with a structural assessment, tongue analysis (shows the level of *ama* (toxins) in the body), and Ayurvedic pulse reading, provide vital clues to your unique body type and current *dosha* state.

We use this information to develop a wellness plan that could include seasonal Ayurvedic dietary recommendations, lifestyle adjustments, specialized body therapy, organics herbal supplements where helpful, posture evaluation, and home therapy tools such as yoga, meditation, and aroma, color and sound therapies. This might sound overwhelming but our approach is to start with the foundation of lifestyle change and guide our clients toward sustainable healthy habits.

We are interested in collaborating with your primary caregiver in your best interest, insofar as you wish. This is helpful for developing the least invasive and most efficient integrated therapy plan for you.

With each follow-up visit we take another step towards wholesome health and wellness. During your time with your practitioner you will learn how Ayurveda works and how to apply the time-tested principles in your daily life on your journey to a healthy, balanced you.

PRIVACY:

All the information provided by you will be kept strictly confidential. If you feel uncomfortable sharing any information please feel free to leave that section blank

DISCLAMER:

Charmaine van Niekerk is a certified Ayurvedic Health Practitioner and professional member of NAMA (National Ayurvedic Medical Association) but she is NOT A LICENSED MEDICAL PRACTITIONER OR HEALTH CARE PROFESSIONAL in the United States of America. Ayurveda consultation and recommendations are not a substitute for medical examination, diagnosis and treatment for any disease, mental or physical, by a licensed medical professional. No modification or change in medical advice should be made without the knowledge and approval of the primary caregiver/medical specialist.

I have read and understand the above information and give my permission to begin an Ayurvedic Health Care program with *Charmaine van Niekerk and Life's a Gift***.**

Patient's Signature:_____ Date: _____

CONFIDENTIAL PATIENT HISTORY

Life's a Gift

Ayurvedic Health Program

(1) PAST MEDICAL HISTORY

Please list any major condition(s) ***and*** *dates of diagnosis, treatment, and procedures performed.*

a. Are you under the care of a licensed health care professional or any other healthcare provider? ☐ Yes ☐ No

If so, for what reasons: _____

_____

b. Serious illnesses: _____

_____

c. Hospitalizations: _____

d. Operations: _____

e. List other pertinent current or past conditions: _____

_____

f. Have you had any cosmetic surgery or procedures performed? ☐ Yes ☐ No

If so, please list: _____

_____

(2) FAMILY HISTORY

Indicate what members of your immediate family have had these conditions. (Go back one generation)

(If adopted, answer according to family heritage, if known.)

☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Other _____

☐ Cancer _____ ☐ Mental Disorder _____ _____

☐ Stroke _____ ☐ Diabetes _____ _____

(3) ALCOHOL, TOBACCO AND SUBSTANCE USE

	PRACTITIONER NOTES:
a. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often: ☐ *Daily* ☐ *Several times weekly* ☐ *Several times monthly* ☐ *Seldom* I usually choose: ☐ beer ☐ wine ☐ sweet or hard liquor	
b. Have you ever smoked tobacco? ☐ Yes ☐ No If yes, how much per day? _____ If you have quit smoking, when did you quit? _____	
c. Any current or past use of addictive or habitual substances? Yes No ***(Note: This will be kept confidential)*** Please list all substances (either current or long-term past usage): _____ _____	

(4) REGULAR PRACTICES

☐ EXERCISE/HATHA YOGA *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ TEAM SPORTS/RECREATION *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ TRAVEL *(Include commute if applicable)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ SPIRITUAL PRACTICES *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ MEDITATION/PRAYER/PRANAYAMA *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ OTHER *(Include creative activities)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*

(5) RELATIONSHIP

a. Please indicate how nourished you feel in your relationship: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(1 being the least nourished, 10 being the most nourished)

b. How often do you engage in sexual activity (include sex with partner and masturbation):

☐ *Daily* ☐ *Several times per week* ☐ *Several times per month* ☐ *Occasionally* ☐ *Not at all*

c. Is your current sexual activity satisfactory? ☐ *Yes* ☐ *No*

Practitioners Notes: _____

(6) FOOD CHOICES

What types of foods do you eat on a regular basis?

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: _____

(7) DAILY LIQUID INTAKE

(Indicate number of 8 ounce cups per day) ❑ Plain water _____

❑ Caffeinated Coffee/Tea _____	❑ Herbal Tea or Juice_____	❑ Cow or Goat Milk _____
❑ Decaffeinated Coffee/Tea _____	❑ Soda or soda pop _____	❑ Grain/nut/soy milk _____

(8) HABITUAL EATING PATTERNS

Describe any current or past eating patterns or any other food related issues.

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(9) DAILY SCHEDULE (include approximate times)

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

		TIME	HABITUAL ACTIVITIES	INTERN NOTES
MORNING	Awaken			
	Mealtime			
	Activities			
DAY	Mealtime			
	Activities			
NIGHT	Mealtime			
	Activities			
	Bed-time			

(10) ALLERGIES OR SENSITIVITIES

Do you have allergic reactions to any substances (including food, pollen, medicines?) If yes, please list.

AYURVEDIC HISTORY

For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to your practitioner about this please check (√) in the column to the right.

CATEGORY				√	PRACTITIONER USE ONLY
Appetite	I prefer to eat frequently but my hunger level is variable, and I often forget to eat. ☐ *Practitioner use only* V☐ P☐	I have a strong appetite I prefer to eat 3x/day and rarely skip meals. ☐ *Practitioner use only* V☐ P☐	I prefer to eat 2-3x/day, but I can go without eating with no discomfort. ☐ *Practitioner use only* V☐ P☐	☐	
Appetite	If I miss a meal, I often get light-headed, anxious or cranky. ☐ *Practitioner use only* V☐ P☐	If I miss a meal, I often get irritable or angry. ☐ *Practitioner use only* V☐ P☐	If I miss a meal, it doesn't really bother me. ☐ *Practitioner use only* V☐ P☐	☐	
Digestion	After eating, I often experience gas or bloating ☐ *Practitioner use only* V☐ P☐	After eating, I often experience heartburn or acidity. ☐ *Practitioner use only* V☐ P☐	After eating, I often feel heavy or sleepy. ☐ *Practitioner use only* V☐ P☐	☐	
Elimination	I tend to have irregular bowel movements one time per day or less. ☐ *Practitioner use only* V☐ P☐	I tend to have 1 to 2 bowel movements daily, usually with regularity and ease. ☐ *Practitioner use only* V☐ P☐	I tend to have one bowel movement per day with no straining or difficulty. ☐ *Practitioner use only* V☐ P☐	☐	
Elimination	My bowel movements are often dry and hard. At times I may strain or push. ☐ *Practitioner use only* V☐ P☐	My bowel movements are usually well-formed, but sometimes they are loose and may burn. ☐ *Practitioner use only* V☐ P☐	My bowel movements are usually well-formed, slow and easy. ☐ *Practitioner use only* V☐ P☐	☐	
Weight	I usually don't gain weight very easily. ☐ *Practitioner use only* V☐ P☐	When I gain weight, it is easy to lose it. ☐ *Practitioner use only* V☐ P☐	I gain weight easily and lose it slowly. ☐ *Practitioner use only* V☐ P☐	☐	
Body Temperature	My hands and feet often feel cold, and I prefer warmer climates. ☐ *Practitioner use only* V☐ P☐	I am warm most of the time no matter what the climate is. ☐ *Practitioner use only* V☐ P☐	I adapt easily to most conditions, but tend to feel cool. ☐ *Practitioner use only* V☐ P☐	☐	
Sleep	I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. ☐ Practitioner use only V☐ P☐	I tend to sleep soundly and awaken with ease. ☐ Practitioner use only V☐ P☐	My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. ☐ Practitioner use only V☐ P☐	☐	

PRACTITIONER USE ONLY

V PRAKRUTI:	**P PRAKRUTI:**	**K PRAKRUTI:**
V VIKRUTI:	**P VIKRUTI:**	**K VIKRUTI:**

CATEGORY				√	PRACTITIONER USE ONLY
MENTAL & EMOTIONAL PATTERNS					
Stress	Under stress I often become worried or overwhelmed. ☐ *Practitioner use only* V☐ P☐	Under stress I often become irritable, but usually rise to the challenge. ☐ *Practitioner use only* V☐ P☐	Under stress, I often withdraw to observe or become reclusive. ☐ *Practitioner use only* V☐ P☐	☐	
Decision Making	I am changeable and often have difficulty making decisions. ☐ *Practitioner use only* V☐ P☐	I make decisions easily, but can change my mind with new information. ☐ *Practitioner use only* V☐ P☐	I am careful but easy-going about decisions. ☐ *Practitioner use only* V☐ P☐	☐	
Projects	I like to start projects, but at times have difficulty finishing them. ☐ *Practitioner use only* V☐ P☐	I like to start and finish projects. Completion is important to me. ☐ *Practitioner use only* V☐ P☐	I like working on a project, but prefer to let others start them. ☐ *Practitioner use only* V☐ P☐	☐	
Personality	When I am balanced I feel creative, enthusiastic, and vivacious. ☐ *Practitioner use only* P☐	When I am balanced I feel perceptive, disciplined, and logical. ☐ *Practitioner use only* P☐	When I am balanced I feel nurturing, calm, and devotional. ☐ *Practitioner use only* P☐	☐	

PRACTITIONER USE ONLY:

V PRAKRUTI:	**P PRAKRUTI:**	**K PRAKRUTI:**
V VIKRUTI:	**P VIKRUTI:**	**K VIKRUTI:**

(11) CHALLENGING PATTERNS

Please indicate any physical and emotional patterns that *you find challenging* by assigning a ***Frequency*** (a number of times per week, month or year) and ***Intensity*** (a number from 1 to 10):

INTENSITY
1 TO 3 = MILD DISCOMFORT
4 TO 6 = MODERATE DISCOMFORT
7 TO 10 = SEVERE DISCOMFORT

EMOTIONS

	Frequency Number of times per week, month or year	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

DIGESTION

	Frequency Number of times per week, month or year	Intensity 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

ELIMINATION

	Frequency Number of times per week, month or year	Intensity 1-10
Constipation (less than 1 BM/day)		
Alternating constipation & diarrhea		
Food particles in stool		
Diarrhea		
Rectal pain or hemorrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

Practitioner Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

Vikruti	V:	P:	K:

Please describe your energy level: _____

(12) CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, and supplements are you currently taking?
Please include significant remedies that you have stopped *taking, including birth control and hormone replacement therapies.*

Substance	Over-the-counter ***(OTC)*** Prescription? ***(Rx)***	Herb/Drug/ Vitamin?	Prescribed by? ***(Self, MD, other)***	For what purpose?	For how long?	What dosage?	What have the benefits been?

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