Health seeker Intake form

Today's Date:	Age:	Gender: ❑ F ❑ M
Name (Last, First, MI):	Height:	Weight:
Address (No. Street):	**Date of Birth:**	Place of Birth:
City, State, Zip Code:	**Phone** (c) (h) (w)	
Email:	**Occupation:**	
❑ **Married** ❑ **Single**	❑ **Divorced/Separated** ❑ **Cohabitating** ❑ **Widowed**	
Emergency Contact Name & Phone Number:	**Referred by:**	

What is your ethnicity?			
❑ Native American	❑ Asian	❑ Hispanic	❑ Mediterranean
❑ African American ❑ Other	❑ South Asian	❑ Caucasian	❑ Northern European

With whom do you live? *Include children, parents, other occupants and pets with ages*

What do you hope to achieve with your health consultation today?

Main problem(s) you would like help with

Describe problem	Since	Mild/Moderate/Severe	Attempted treatment and response

Mild – some discomfort, Moderate – creates much trouble, but can continue regular activities, severe – restricts your daily routine

Are you diagnosed with any medical conditions?

Conditions	Since when	Control status	Treating physician, affiliation

Are you taking any prescription medications?

Medication Name	Started in	Dosage	Prescribed by

Are you taking any herbal or alternative medicine?

Name	Started in	Dosage	Prescribed by

Are you taking any vitamins or nutritional supplements?

Name with dose of main ingredients	Since when	Regularly	Given by

e.g. One a Day, Centrum, other vitamins

Were there any diseases that you suffered from earlier?

Disease	From when to when	Treatment – drugs, exercise, etc.

Include major infections like typhoid, malaria, hepatitis

Have you had any kind of surgery or minor procedures performed on you?

Procedure	When	Who and where performed

Include any Panchakarma, Acupuncture and other treatments here as well

Please list any hospitalizations

Year	Condition	Procedure done

Family History *Fill only the positive yes as 'Y' or a tick mark*

	Father	Mother	Brother(s)	Sister(s)	PGM	PGF	MGM	MGF
Diabetes								
Hypertension								
Heart Disease								
Stroke								
Asthma								
Cancer (type)								
Hypothyroid								

Arthritis								
Other								
If not living, age at and cause of death								

PGM, PGF = Paternal grandmother, grandfather; MGM, MGF =maternal grandmother, grandfather

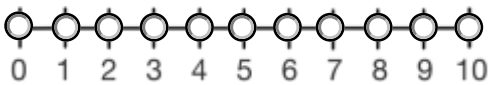
How much do you move?

Activity	**Intensity**	**Hours**	**Days/ week**	**Since**
How often do you break a sweat with exercise? (times/week)				
How many hours do you watch TV every week?				
Do you watch TV, read or surf while eating meals?				

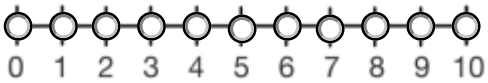
Do you connect with yourself? How and how often? *Hobbies/music/ meditation/ community service etc.*

On a scale of 1 to 10, please indicate in the past week:

How stressed you have been? *0 – not at all, 10 extreme*

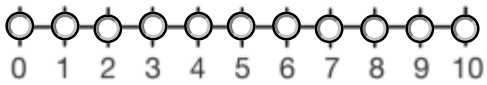


What is your energy level? *0 – very poor, I can barely get through the day, 10 – excellent, I can do more!*



Rate on a scale of 0 to 10, how hungry do you feel at different meal times?

0 – not at all 1-3 – mildly hungry 4-7 moderately hungry, 8-9 – quite hungry 10 – very hungry!



	Example	Morning	Mid - morning	Lunch	Snack	Evening	Dinner	Bedtime
Time	11am							
How hungry	8							

Rate on a scale of 1-5 how the following applies

If 1= Always, 2= Often, 3=Sometimes, 4=Rarely, 5=Never

	Rate	***If 3 or below, it indicates***
Is the above pattern mentioned irregular?		*Vāta (Vishama)*
Can you skip meals easily?		*Kapha / Āma (Manda)*
Are you mostly always ready to eat – whatever the time of the day it maybe?		*Pitta (Tikshna)*
If hunger is not gratified, do you feel uncomfortable or irritable?		*Pitta (Tikshna) / (Vāta)*
Do you end up feeling fuller earlier than expected at the start of a meal?		*Āma / Vāta (Manda / Vishama)*
Are there times when even little quantity of food doesn't get digested for a long time?		*Āma (Manda)*
Does your food get digested well on some days and sometimes not?		*Vāta (Vishama)*

Habits *Please indicate usage: none, light, moderate, or heavy. Add comments where significant.*

	Heavy	Moderate	Light	None	Comments
Alcohol	❑	❑	❑	❑	
Coffee	❑	❑	❑	❑	
Tea	❑	❑	❑	❑	
Tobacco	❑	❑	❑	❑	
Marijuana	❑	❑	❑	❑	
Other	❑	❑	❑	❑	

Personal Preference

Which weather do you prefer?	Warm / Cool / Both
Which extreme of weather are you unable to tolerate?	Hot / Cold / Neither
Which taste do you prefer?	Sweet/ Sour/ Salty/ Hot/ Bitter/ Astringent
How thirsty do you feel?	Often / Moderate / Not much
Do you sweat easily?	Often / Not that much / Rarely
What is your basic nature?	Extrovert / Introvert
What makes you happy?	

Please indicate below any symptoms you have experienced in the last three months:

General

- ❑ Poor appetite
- ❑ Cravings
- ❑ Change in appetite
- ❑ Peculiar tastes/smells
- ❑ Strong thirst – hot
- ❑ Strong thirst – cold
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Fevers
- ❑ Chills
- ❑ Tremors
- ❑ Poor balance
- ❑ Localized weakness
- ❑ Bleed/bruise easily
- ❑ Sudden energy drop
- ❑ *Time(s) of day:* _____ _____ _____

Skin and Hair

- ❑ Rashes
- ❑ Skin tags
- ❑ Itching
- ❑ Change in skin/hair texture
- ❑ Hives
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff
- ❑ Other skin/hair problems:
- ❑ Pimples

Head

- ❑ Dizziness
- ❑ Facial pain
- ❑ Migraines
- ❑ Headaches
- ❑ Other head/neck problems:

Eyes, Ears, Nose and Throat

- ❑ Glasses
- ❑ Poor vision
- ❑ Cataracts
- ❑ Eye strain
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Color blindness
- ❑ Eye pain
- ❑ Spots in vision
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Ear aches
- ❑ Nose bleeds
- ❑ Sinus problems
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ Recurrent sore throats
- ❑ Sores on lips or tongue
- ❑ Jaw clicks

Cardiovascular

- ❑ Swelling of feet
- ❑ Low blood pressure
- ❑ Difficulty breathing
- ❑ Irregular heartbeat
- ❑ Chest pain
- ❑ Fainting
- ❑ Dizziness
- ❑ Venous swelling
- ❑ Blood clots
- ❑ Cold hands
- ❑ Swelling of hands
- ❑ Cold feet
- ❑ Other problems with heart or blood vessels: _____

Respiratory

- ❑ Cough
- ❑ Coughing blood
- ❑ Pain with deep breath
- ❑ Difficulty lying down
- ❑ Phlegm color:
- ❑ Other: _____

Musculoskeletal

- ❑ Neck pain
- ❑ Back pain
- ❑ Shoulder pain
- ❑ Hand/wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Other muscle pain
- ❑ Muscle weakness
- ❑ Other: _____

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Belching
- ❑ Indigestion
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Abdominal pain/cramps
- ❑ Chronic laxative use
- ❑ Other problems with stomach or intestines: _____

Genito – Urinary

- ❑ Frequent urination
- ❑ Pain on urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Kidney stones
- ❑ Impotency
- ❑ Excessive sexual urge
- ❑ Wake up to urinate how often:

Neuropsychological

- ❑ Lack of coordination
- ❑ Easily susceptible to stress
- ❑ Areas of numbness
- ❑ Treated for emotional problems
- ❑ Depression
- ❑ Bad temper
- ❑ Poor memory
- ❑ Anxiety
- ❑ Seizures
- ❑ Concussion
- ❑ Dizziness
- ❑ Loss of balance
- ❑ Other:

_____

_____

_____

Pregnancy and Gynecology

- ❑ Painful periods
- ❑ Clots
- ❑ Irregular periods
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Breast lumps
- ❑ Premenstrual symptoms
- ❑ Unusual character (heavy or light)
- ❑ Use birth control
- ❑ *Type:*_____
  How long: _____
- ❑ No. of pregnancies: _____
- ❑ No. of births: _____
- ❑ No. of premature births: _____
- ❑ No. of miscarriages: _____
- ❑ No. of abortions: _____
- ❑ Age at first menses: _____
- ❑ Date of last menses: _____
- ❑ Menses duration: _____
- ❑ Length of full cycle: _____
- ❑ Date of last PAP: _____

Satori Spinal Wisdom, LLC
7075 Campus Dr. Ste 210, Colorado Springs, CO 80920
719-785-1175

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date:

We keep medical records of the health care services we provide for you. You may ask to see and copy your records. You may ask to correct your records. Your records will be kept confidential unless you give us written permission to release them or we are required to do so by law.

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of consultations, payment and health technique operations in this office. You may see your records or get more information about them by contacting our office.

For more information about our privacy practices please inquire with us.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Rogi/Patient or legal representative Date

Satori Spinal Wisdom, LLC
7075 Campus Dr. Ste 210, Colorado Springs, CO 80920
719-785-1175

Name : _____Date:_____

Welcome to Satori Spinal Wisdom, LLC. Ayurveda is the 5000-year-old Wisdom of Healthy living. It is a way of natural healing and emphasizes on maintaining the harmony of Body-Mind-Spirit through diet, life style, and natural herbs. In Ayurveda the emphasis is not on a disease but on maintaining the balance of individual Body Constitution, so Ayurvedic treatments are never one size fits all, but they are custom tailored for each individual need. The Ayurvedic services you can receive are as follows:

- Body - Constitutional analysis
- Diet and the life style counseling
- Ayurvedic body techniques
- Yoga and meditation Practices

Our method of treatment in Ayurveda is alternative or complementary to conventional medicine. If you ever have any concerns about the nature of your Ayurvedic services, please feel free to discuss them with us. We recommend that you inform your medical doctor that you are receiving Ayurvedic advises.

I have read and understood the above disclosure about the Ayurvedic services offered by Satori Spinal Wisdom, LLC

_____ _____
Signature of Rogi/Patient Date

_____
Printed Name of Rogi/Patient

_____
Signature of Parent or Legal Guardian
(If Rogi/Patient is under 18yrs of age)

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MISSED APPOINTMENT POLICY

Please give us at least 48 hours cancellation notice for an initial appointment, and 24 hours notice for follow-up appointment. This allows us to call those waiting for an appointment to take your place.

Please also be aware that the clinic allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

Any missed appointment without prior notice will be billed as a full office charge.

I have read and agree to this missed appointment policy.

_____ _____
Signature of Rogi/Patient Date

_____
Printed Name of Rogi/Patient

_____
Signature of Parent or Legal Guardian
(If Rogi/Patient is under 18yrs of age)