



I N F O R M E D C O N S E N T

To authorize complementary or alternative health care

All Patients who participate in Ayurvedic health care through this program should be advised of the following information:

I, _____, hereby agree to the following:

1. I am participating in Yoga classes, health programs, or workshops offered by Sattva Veda. During which I will receive information and instruction about Yoga and health. I recognize that Yoga requires physical exertion, which maybe strenuous and may cause physical injury and I am fully aware of the risks and hazards involved.
2. I understand it is my responsibility to see a physician prior to and regarding my participation in Yoga classes, health programs, or workshops. I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in Yoga classes, health programs, or workshops.
3. In consideration of being permitted into Yoga classes, health programs, or workshops I agree to assume full responsibility for any risks, injuries, or damages known or unknown which I might incur as a result of participating in the program.
4. In further consideration of being permitted to participate in the Yoga classes, health programs, and workshops I knowingly, voluntarily, and expressly waive any claim I may have against Sattva Veda for any injury or damages that I sustain as a result of participating in the program.
5. I, my heirs, or legal representatives forever release, waive, discharge, and covenant not to sue Sattva Veda for any injury or death caused by their negligence or other act.
6. Practitioners of Sattva Veda are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
7. A Practitioner of Sattva Veda is not a Medical Doctor.
8. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003.
9. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If you are referred to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
10. Ayurvedic Practitioners of Sattva Veda will not alter your prescriptions without the approval of your Medical Doctor. They may suggest that you speak to your Doctor about reducing medication when he/she feels that it is appropriate.
11. Although your Practitioner may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, they are evaluating their findings from an Ayurvedic perspective only and not from a Western medical perspective. This examination does not take the place of a medical evaluation. If, as a result of their examination, any findings suggestive of a possible medical imbalance is found, the Practitioner will refer you to a Medical Doctor for further evaluation.

I have read the above release and liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian's Signature: _____
(if Patient is under 18 years of age)

PATIENT NAME: _____

Intake 2



CONFIDENTIAL PATIENT HISTORY

What you can expect from your Ayurvedic health care

Ayurveda is a natural healing system that has been successfully practiced for thousands of years. Originating in ancient India, this medical tradition states that each person's path toward optimal health is unique – because each person is unique. The healing programs we offer at Sattva Veda are based on effective, time-honored principles that focus on understanding your particular body-mind constitution and the unique nature of your imbalance.

Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other natural therapeutics. In order to successfully implement these Ayurvedic principles into your life, frequent regular follow-up visits with your practitioner are recommended over a six to twelve month period.

The goal of all Ayurvedic 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.

Patient's Signature: _____ Date: _____

Initial Appointment: _____ \ _____ \ _____

ROF Date: _____ \ _____ \ _____

Past Medical History

Include major conditions and dates of treatment and procedures performed.

a. Serious Illnesses: _____

b. Hospitalizations: _____

c. Operations: _____

d. List other pertinent past conditions: _____

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

If so, for what reasons: _____

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

If so, please list with dates: _____

PATIENT NAME: _____

Intake 3

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 _____

Alcohol, Tobacco and Substance Use

PRACTITIONER NOTES

<p>a. Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how often: <input type="checkbox"/> Daily <input type="checkbox"/> Several times weekly <input type="checkbox"/> Several times monthly <input type="checkbox"/> Seldom</p> <p>I usually choose: <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Sweet or hard liquor</p>	
<p>b. Have you ever smoked tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how much per day _____</p> <p>If you have quit smoking, when did you quit? _____</p>	
<p>c. Any current or past use of addictive or habitual substances? <input type="checkbox"/> Yes <input type="checkbox"/> No (note: this will be kept confidential)</p> <p>_____</p> <p>_____</p>	

Regular Practices

<input type="checkbox"/> Exercise / Hatha Yoga (Specify)	<input type="checkbox"/> None / Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several time per month
<input type="checkbox"/> Team Sports / Recreation (Specify)	<input type="checkbox"/> None / Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several time per month
<input type="checkbox"/> Travel (Include commute if applicable)	<input type="checkbox"/> None / Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several time per month
<input type="checkbox"/> Spiritual Practices (Specify)	<input type="checkbox"/> None / Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several time per month
<input type="checkbox"/> Meditation / Prayer / Pranayama (Specify)	<input type="checkbox"/> None / Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several time per month
<input type="checkbox"/> Other (Include creative activities)	<input type="checkbox"/> None / Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several time per month

Sexual Activity

According to Ayurveda, a person's level of sexual activity impacts health and well-being in the same way as other aspects of daily life – such as diet or sleep.

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

Daily Several times a week Several times a month Occasionally Not at all

b. Is your current sexual activity satisfactory? Yes No

PATIENT NAME: _____

Food Choices

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

Breakfast:

Lunch:

Dinner:

Snack:

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	PRACTITIONER NOTES
Morning	Awaken			
	Mealtime			
	Activities			
Day	Mealtime			
	Activities			
Night	Mealtime			
	Activities			
	Bedtime			

Daily Liquid Intake (indicate number of 8 ounce cups per day)

- Caffeinated Coffee / Tea
 Herbal Tea or Juice
 Cow or Goat Milk
 Plain Water
 Decaffeinated Coffee / Tea
 Soda or Soda pop
 Grain / Nut / Soy Milk

Allergies or Sensitivities

Do you have allergic reactions to any substances (including food, pollens, and medicines)? If yes, please list:

Habitual Eating Patterns

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

PATIENT NAME: _____



Challenging Patterns

Please indicate any physical and emotional patterns that you find challenging by assigning a **Frequency** (a number from 1 to 3) and **Intensity** (a number from 1 to 10).

FREQUENCY	INTENSITY
1 = Daily	1 to 3 = Mild Discomfort
2 = Several Times Weekly	4 to 6 = Moderate Discomfort
3 = Several Times Monthly	7 to 10 = Severe Discomfort

C. EMOTIONS

	Frequency 1-3	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-Destructiveness		
Anger		
Resentment		
Critical / Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

A. DIGESTION

	Frequency 1-3	Intensity 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

B. ELIMINATION

	Frequency 1-3	Intensity 1-10
Constipation (less 1 BM / day)		
Alternating constipation & diarrhea		
Food particles in stool		
Rectal pain or hemorrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

Additional Symptoms of Concern

	Frequency 1-3	Intensity 1-10

Previously Diagnosed Current Conditions

	Practitioner Notes

PATIENT NAME: _____

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	My hunger level is variable and I often forget to eat. <input type="checkbox"/>	I have a strong appetite and don't like to miss meals. <input type="checkbox"/>	I like to eat but I can go without eating with no discomfort. <input type="checkbox"/>		
Appetite	If I miss a meal, I often get light-headed, anxious or cranky <input type="checkbox"/>	If I miss a meal, I often get irritable or angry. <input type="checkbox"/>	If I miss a meal, it doesn't really bother me. <input type="checkbox"/>		
Appetite	I prefer to eat frequently with no set schedule, but I often forget to eat. <input type="checkbox"/>	I prefer to eat 3 meals a day at about the same time each day. I rarely skip meals. <input type="checkbox"/>	I prefer to eat 2 to 3 times daily, but can go without eating. <input type="checkbox"/>		
Digestion	After eating, I often experience gas or bloating. <input type="checkbox"/>	After eating, I often experience heartburn or acidity. <input type="checkbox"/>	After eating, I often feel heavy or sleep. <input type="checkbox"/>		
Elimination	I tend to have irregular bowel movements one time per day or less. <input type="checkbox"/>	I tend to have 1 to 2 bowel movements daily, usually with regularity and ease. <input type="checkbox"/>	I tend to have one bowel movement per day with no straining or difficulty. <input type="checkbox"/>		
Elimination	My bowel movements are often dry and hard. At times I may strain to push. <input type="checkbox"/>	My bowel movements are usually well-formed, but sometimes they are loose and may burn. <input type="checkbox"/>	My bowel movements are usually well-formed, slow and easy. <input type="checkbox"/>		
Weight	I usually don't gain weight very easily. <input type="checkbox"/>	When I gain weight, it is fairly easy to lose it. <input type="checkbox"/>	I gain weight easily and lose it slowly. <input type="checkbox"/>		
Body Temperature	My hands and feet often feel cold and I prefer warmer climates. <input type="checkbox"/>	I am warm most of the time no matter what the climate is. <input type="checkbox"/>	I adapt easily to most conditions, but tend to feel cold. <input type="checkbox"/>		
Skin	My skin tends to be dry. When very dry it tends to feel rough. <input type="checkbox"/>	My skin flushes easily and has a reddish or yellowish shade. <input type="checkbox"/>	My skin is thick, smooth and often feels damp or oily. <input type="checkbox"/>		

Below for Practitioner Use Only:

V Prakriti:	P Prakriti:	K Prakriti:
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PATIENT NAME: _____

Intake 7



CATEGORY				✓	PRACTITIONER USE ONLY
Skin	When I have rashes, they tend to be dry and itchy. Blemishes are usually blackheads. <input type="checkbox"/>	When I have rashes, they tend to be red and burning, Blemishes are usually ache. <input type="checkbox"/>	When I have rashes, they tend to be wet and oozing. Blemishes are usually white pimples. <input type="checkbox"/>		
Sleep	I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. <input type="checkbox"/>	I tend to sleep soundly and awaken with ease. <input type="checkbox"/>	My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. <input type="checkbox"/>		

Mental & Emotional Patterns

Stress	Under stress I often become worried or overwhelmed. <input type="checkbox"/>	Under stress I often become irritable, but usually rise to the challenge. <input type="checkbox"/>	Under stress, I often withdraw to observe or become reclusive. <input type="checkbox"/>		
Decision Making	I am changeable and often have difficulty making decisions. <input type="checkbox"/>	I make decisions easily, but can change my mind with new information. <input type="checkbox"/>	I am careful but easy-going about decisions. <input type="checkbox"/>		
Projects	I like to start projects, but at times have difficulty finishing them. <input type="checkbox"/>	I like to start and finish projects. Completion is important to me. <input type="checkbox"/>	I like working on a project, but prefer to let others start them. <input type="checkbox"/>		

For Women Only

	Is there a possibility you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possible		I experience PMS:		
	Are you menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last period: _____		<input type="checkbox"/> Often <input type="checkbox"/> Sometimes		
	If menopausal, please answer below according to your past menstrual patters.		<input type="checkbox"/> Not at all		
	My menstrual cycle is irregular. It comes every ____ to ____ days and lasts ____ days. <input type="checkbox"/>	My menstrual cycle is regular. It comes every ____ to ____ days, and lasts ____ days. <input type="checkbox"/>	<input type="checkbox"/> Cramps <input type="checkbox"/> Bloating	<input type="checkbox"/> Headache <input type="checkbox"/> Weight gain	
			<input type="checkbox"/> Irritable <input type="checkbox"/> Breast Tenderness		
	My menstrual flow is often light, but may vary <input type="checkbox"/>	My menstrual flow is medium heavy, and is usually consistent. <input type="checkbox"/>	My menstrual flow is heavy and is very consistent. <input type="checkbox"/>		
	I often have sever, cramping pain during menses. <input type="checkbox"/>	I sometimes have mild pain during menses. <input type="checkbox"/>	I rarely have pain during menses. <input type="checkbox"/>		

Below for Practitioner Use Only:

V Prakruit:	P Prakruti:	K Prakruti:
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PATIENT NAME: _____

Intake 8



