INNER SENSES

AYURVEDIC HEALTH QUESTIONAIRE

Name: ______________________ Email: ______________________

Age: ______________ Gender: M/F Present occupation: ______________________

Adress: ______________________ Past occupation: ______________________

Place of birth: ______________________ Marital status: ______________________

Countries lived: ______________________ Children with ages: ______________________

Frequency of travel: ______________________ Educational status: ______________________

Family Medical history: (father): ______________________

(mother): ______________________

Chief concerns of patient: ______________________

Are you taking Medication/ Herbs (past, present): ______________________

Do you suffer from any of the following symptoms:

- ☐ Disinterest in food
- ☐ Nausea
- ☐ Whole body ache
- ☐ Anaemia
- ☐ Weight loss
- ☐ Constipation
- ☐ Skin erruptions
- ☐ Mouth Ulcers
- ☐ Gas in bowel
- ☐ Jaundice
- ☐ Allergies
- ☐ Cancer
- ☐ Feet or ankle swelling
- ☐ Kidney/ bladder disease
- ☐ Shortness of breath
- ☐ Distaste in the mouth
- ☐ Heaviness of body
- ☐ Fever
- ☐ Blockage of channels
- ☐ Poor digestion
- ☐ Irratable bowel
- ☐ Bleeding disorder
- ☐ Ulcers in private parts
- ☐ Abcess
- ☐ Psoriasis
- ☐ Arthritis
- ☐ Chest pain Angina
- ☐ Heart problems
- ☐ Pain/ ringing in ear
- ☐ Burn out
- ☐ No taste sensation
- ☐ Drowsiness
- ☐ Black out
- ☐ Tiredness
- ☐ Acidity
- ☐ Diahorea
- ☐ Excessive Menstrual Bleeding
- ☐ Enlarged spleen/ Liver
- ☐ Moles/ pigmentation
- ☐ Eczema
- ☐ Blood pressure High/low
- ☐ Diabetes
- ☐ Surgery
- ☐ Psychological disturbances
- ☐ Anxiety/ stress

Please list any history of illness with dates: ______________________

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Please describe any other conditions that are currently bothering you (aches, pain, stress, fatigue, energy levels, mental clarity, concentration, vision, hot flushes, chills, nervousness):

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Sleep habits: ______________________________

How regular are your periods (F): ______________ Malas: Urine/ Sweat: ______________

How regular are bowel movements:
- ☐ watery/ acidic
- ☐ dry/ pellets
- ☐ soft/ sticky
- ☐ broken/narrow
- ☐ one piece/ floats

What do you want to achieve in terms of health and wellness: ______________________________

Do you excercise? ______________________________

Meditation, pranayama, yoga? ______________________________

Food habits: ______________________________

Diet: ______________________________

Practitioner notes (not to be filled in by patient)!

Appetite: ______________ Weight: ______________

Food sensitivities: ______________ Gums: ______________

Examiners use only: ______________ Quality of hands/ nails: ______________

Tongue: ______________ Hair quality: ______________

Pulse: ______________ Mental Nature: ______________

Urine: ______________ Speech: ______________

Eyes: ______________ Emotional response: ______________

Abdomen: ______________ Relationships/ social skills: ______________

Touch/ skin temp: ______________ ______________

Skin: ______________ Build: ______________

Dominant dosha: ______________ Pakruti: V P K ______________

Dosha affected: ______________ Ama: ______________

Dhatus/ srotas: ______________ Lifestyle, causes of problem: ______________

Recommendations

Herbs: ______________________________

Diet: ______________________________

Pranayama: ______________________________

Yoga: ______________________________

Lifestyle: ______________________________

Treatments: ______________________________