Health Information and History

Please fill out this information as best as you can. If you are unclear on questions we can discuss them during our visit. Some questions may seem unrelated to your condition, yet they do help us in creating a deeper understanding of your individuality. *All information will be held strictly confidential.*

General Information

Name:______________________________ Date:______________

Address: ______________________________

City:______________________________ State:________ Zip Code: __________

Home Phone:______________ Work Phone: ______________ Cell Phone:______________

Email:______________________________

Emergency Contact:______________________________ Phone:______________

Occupation:______________________ Employer:______________________

Guardian (if under 18):______________________________

Age:______ DOB: _____/_____/_____ Place of Birth: City:____________________ State:________

Relationship Status: ______________________ Height: __________ Weight: __________

Children: __________ Do you share your home with if others if so whom? ______________________

____

Referred by:______________________ Family Physician:______________________

Objectives

What do you want to achieve or change in terms of your health and wellness?______________________

____

____

How would your life be different if you were to achieve these objectives to your satisfaction?______________

____

____

Personal History

How was your childhood health?______________________________

Hospital Visits/Stays:______________________________

____

JENNIFER CARLSON
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NEWINGTON, NH 03801
603-431-6677 EXT 238

Do you or your family members have a history of:

		Family Member				Family Member	
	Myself	**Maternal**	**Paternal**		**Myself**	**Maternal**	**Paternal**
Allergies to Food or Drugs	Yes[ ]	Yes[ ]	Yes[ ]	Hepatitis Non-A, Non-B	Yes[ ]	Yes[ ]	Yes[ ]
Anemia	Yes[ ]	Yes[ ]	Yes[ ]	High Fever	Yes[ ]	Yes[ ]	Yes[ ]
Arthritis	Yes[ ]	Yes[ ]	Yes[ ]	HIV Exposure	Yes[ ]	Yes[ ]	Yes[ ]
Asthma, Pneumonia, TB	Yes[ ]	Yes[ ]	Yes[ ]	Implant, Prosthesis	Yes[ ]	Yes[ ]	Yes[ ]
Blood Pressure – High or Low	Yes[ ]	Yes[ ]	Yes[ ]	Kidney or Bladder Disease	Yes[ ]	Yes[ ]	Yes[ ]
Cancer:______________________	Yes[ ]	Yes[ ]	Yes[ ]	Measles	Yes[ ]	Yes[ ]	Yes[ ]
Chemotherapy/Radiation Treatment	Yes[ ]	Yes[ ]	Yes[ ]	Meningitis	Yes[ ]	Yes[ ]	Yes[ ]
Chest Pain/Angina	Yes[ ]	Yes[ ]	Yes[ ]	Mononucleosis, Jaundice, Gallstone	Yes[ ]	Yes[ ]	Yes[ ]
Chicken Pox	Yes[ ]	Yes[ ]	Yes[ ]	Multiple Sclerosis	Yes[ ]	Yes[ ]	Yes[ ]
Contact Lenses	Yes[ ]	Yes[ ]	Yes[ ]	Mumps	Yes[ ]	Yes[ ]	Yes[ ]
Dental Treatment Complications	Yes[ ]	Yes[ ]	Yes[ ]	Nervous Disorder	Yes[ ]	Yes[ ]	Yes[ ]
Diabetes	Yes[ ]	Yes[ ]	Yes[ ]	Pain or Ringing in the Ear	Yes[ ]	Yes[ ]	Yes[ ]
Dizziness	Yes[ ]	Yes[ ]	Yes[ ]	Paralysis	Yes[ ]	Yes[ ]	Yes[ ]
Emphysema	Yes[ ]	Yes[ ]	Yes[ ]	Polio	Yes[ ]	Yes[ ]	Yes[ ]
Epilepsy, Convulsions, Seizures	Yes[ ]	Yes[ ]	Yes[ ]	Popping, Clicking, Locking of the Jaw	Yes[ ]	Yes[ ]	Yes[ ]
Fainting	Yes[ ]	Yes[ ]	Yes[ ]	Prolonged Bleeding when Cut	Yes[ ]	Yes[ ]	Yes[ ]
Feet or Ankles, Swelling	Yes[ ]	Yes[ ]	Yes[ ]	Psychiatric Treatment	Yes[ ]	Yes[ ]	Yes[ ]
Glaucoma, Eye Surgery	Yes[ ]	Yes[ ]	Yes[ ]	Rheumatic Fever	Yes[ ]	Yes[ ]	Yes[ ]
Headaches, Migraines	Yes[ ]	Yes[ ]	Yes[ ]	Shortness of Breath	Yes[ ]	Yes[ ]	Yes[ ]
Heart Attack	Yes[ ]	Yes[ ]	Yes[ ]	Stroke / Cerebro Vascular Accident	Yes[ ]	Yes[ ]	Yes[ ]
Heart Disease, Heart Murmur	Yes[ ]	Yes[ ]	Yes[ ]	Thyroid Disease or Medication	Yes[ ]	Yes[ ]	Yes[ ]
Heart Surgery	Yes[ ]	Yes[ ]	Yes[ ]	Ulcers, Intestinal Bleeding	Yes[ ]	Yes[ ]	Yes[ ]
Hepatitis A	Yes[ ]	Yes[ ]	Yes[ ]	Upper respiratory problems	Yes[ ]	Yes[ ]	Yes[ ]
Hepatitis B	Yes[ ]	Yes[ ]	Yes[ ]	Venereal Diseases	Yes[ ]	Yes[ ]	Yes[ ]

History of any other disease or problems? (Please list any other illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, lifestyle conditions, addictions, alcohol, drug abuse, changes of weight or anything else to help clearly understand your health condition)

____

____

____

Family history: Any other family illnesses?____

____

____

____

____

Concerns: Major concerns/complaint(s), in order of significance to you (please note how long they have troubled you):

1. ____
2. ____
3. ____
4. ____

How do these conditions impair your daily activities?_________________________________

____

____

Please describe any other conditions that are currently bothering you, such as: Aches, pains, degenerative illnesses, anxiety, depression, stress, fatigue, energy levels, mental clarity, concentration, insomnia, vision, fever, hot flashes, chills, nausea, constipation, diarrhea, sleep habits, nervousness or other conditions you can think of.

____

____

____

____

Current treatment: Are you currently under a physician's care for a specific medical problem or condition? If so, what?

____

____

Last physical examination (date)?____

What prescription drugs or medications are you currently taking?________________________________

____

____

What non-prescription drugs, medications or substances or recreational drugs are you taking? (Please note duration)

____

What surgeries have you had? (Please list dates)____

____

Other: Do you currently engage in any exercise or physical activity? If so, what type and how often?________________

____

Have you ever done Yoga postures before? If so, what type and how often?___________________________

____

Gender specific: Women: Age of first menstruation:________________ Last menstrual period?__________________

Are your periods regular?__________ How long does your period last?_____________________ Do you have bleeding between periods? ________________________ Any clotting?________________ What color is the blood?___________

Days between periods (i.e., days between the first day of each period)?_______ Do you have vaginal discharge?_______

Are you pregnant?__________ Number of pregnancies?____________ Number of children?______________________

Do you experience any of the following pre-menstrual or menstrual symptoms:

Fear, anxiety	[ ]	Irritability	[ ]	Depression	[ ]
Scanty, infrequent or no menstruation	[ ]	Profuse menstrual flow	[ ]	Prolonged, slow menstrual cycle	[ ]
Sharp pain	[ ]	Burning pain	[ ]	Dull pain	[ ]
		Sensitive nipples	[ ]	Enlargement of breasts	[ ]
		Tender breasts	[ ]	Edema (swelling)	[ ]

Please describe any other menstrual symptoms, such as: Nausea, vomiting, food cravings, headaches, migraines, other emotions, etc.: ____

____

Age of menopause (if applicable):____

Gender specific: Men: Do you have any of the following symptoms:

Testicular pain	[ ]	Swollen testes	[ ]
Impotence	[ ]	Premature ejaculation	[ ]

Please describe any other symptoms: ____

____

Both genders: (Please circle) Would you describe your libido as Low Average High

Please describe any urinary symptoms, such as: Difficult, burning, painful, frequent, urgent, etc.:

____

Please describe any bowel symptoms, such as: Pain, gas, blood, mucous, etc.:______________________________

____

WHAT IS YOUR BODY TYPE?

Determine your body type by answering the below questions. Check the answer that best fits your long term experience. If two answers fit, check them both. If no answer fits, leave it blank. Total up each profile and then add them for a grand total – and your current body type, which is called VIKRUTI in Ayurveda.

	Vata	Pitta	Kapha
Mental Profile			
Mental activity	☐ Quick mind, restless	☐ Sharp intellect, aggressive	☐ Calm, steady, stable
Memory	☐ Short-term best	☐ Good general memory	☐ Long-term best
Thoughts	☐ Constantly changing	☐ Fairly steady	☐ Steady, stable, fixed
Concentration	☐ Short-term focus best	☐ Better than average mental concentration	☐ Good ability for long-term focus
Ability to learn	☐ Quick grasp of learning	☐ Medium to moderate grasp	☐ Slow to learn new things
Dreams	☐ Fearful, flying, running, jumping	☐ Angry, fiery, violent, adventurous	☐ Include water, clouds, relationships, romance
Sleep	☐ Interrupted, light	☐ Sound, medium	☐ Sound, heavy, long
Speech	☐ Fast, sometimes missing words	☐ Fast, sharp, clear-cut	☐ Slow, clear, sweet
Voice	☐ High pitch	☐ Medium pitch	☐ Low pitch
Mental Subtotal			

Behavioral Profile			
Eating speed	☐ Quick	☐ Medium	☐ Slow
Hunger level	☐ Irregular	☐ Sharp, needs food when hungry	☐ Can easily miss meals
Food and drink	☐ Prefers warm	☐ Prefers cold	☐ Prefers dry and warm
Achieving goals	☐ Easily distracted	☐ Focused and driven	☐ Slow and steady
Giving/donations	☐ Gives small amounts	☐ Gives nothing, or large amounts infrequently	☐ Gives regularly and generously
Relationships	☐ Many casual	☐ Intense	☐ Long and deep
Sex drive	☐ Variable or low	☐ Moderate	☐ Strong
Works best	☐ While supervised	☐ Alone	☐ In groups
Weather preference	☐ Aversion to cold	☐ Aversion to heat	☐ Aversion to damp, cool
Reaction to stress	☐ Excites quickly	☐ Medium	☐ Slow to get excited
Financial	☐ Doesn't save, spends quickly	☐ Saves, but big spender	☐ Saves regularly, accumulates wealth
Friendships	☐ Tends toward short-term friendships, makes friends quickly	☐ Tends to be a loner, friends related to occupation	☐ Tends to form long-lasting friendships
Behavioral Subtotal			

Emotional Profile			
Moods	☐ Change quickly	☐ Change slowly	☐ Steady, unchanging
Reacts to stress with	☐ Fear	☐ Anger	☐ Indifference
More sensitive to	☐ Own feelings	☐ Not sensitive	☐ Others' feelings
Relations with spouse/partner	☐ Clingy	☐ Jealous	☐ Secure
Expresses affection	☐ With words	☐ With gifts	☐ With touch
When feeling hurt	☐ Cries	☐ Argues	☐ Withdraws
Emotional trauma causes	☐ Anxiety	☐ Denial	☐ Depression
Confidence level	☐ Timid	☐ Outwardly self-confident	☐ Inner confidence
Emotional Subtotal			

Physical Profile			
Amount of hair	☐ Average	☐ Thinning	☐ Thick
Hair type	☐ Dry	☐ Normal	☐ Oily
Hair color	☐ Light brown, blonde	☐ Red, auburn	☐ Dark brown, black
Skin	☐ Dry, rough, or both	☐ Soft, normal to oily	☐ Oily, moist, cool
Skin temperature	☐ Cold hands/feet	☐ Warm	☐ Cool
Complexion	☐ Darker	☐ Pink-red	☐ Pale-white
Eyes	☐ Small	☐ Medium	☐ Large
Whites of eyes	☐ Blue/brown	☐ Yellow or red	☐ Glossy white
Size of teeth	☐ Very large or very small	☐ Medium	☐ Medium-large
Weight	☐ Thin, hard to gain	☐ Medium	☐ Heavy, gains easily
Elimination	☐ Dry, hard, thin, easily constipated	☐ Many during day, soft to normal	☐ Heavy, slow, thick, regular
Heart Beats per minute	☐ Male 70-90/Female 80-100	☐ Male 60-70/Female 70-80	☐ Male 50-60/Female 60-70
Physical Subtotal			

Grand Total			

RELEASE OF HEALTHCARE INFORMATION

Patient Name____ Date of Birth____________

Office to Release:

______________________________________Phone________________Fax_________________

Address____

Office to Receive:

______________________________________Phone________________Fax_________________

Address____

Please initial next to information to be released:

______ Medical History/ Treatment Records/ Progress Notes
______ Last Annual Exam and Pap Test
______ Laboratory/ Diagnostic Tests ______ All
______ Sexually Transmitted Diseases
______ HIV/ AIDS
______ Drug or Alcohol Abuse/ Treatment
______ Mental Health Illness/ Treatment
______ Immunization Records
______Other____

I understand that:

- I can see and copy the health information described above.
- I can refuse to sign this authorization and that my refusal will not affect payment, eligibility for benefits or my ability to obtain treatment.
- I can revoke this authorization in writing to the address above at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization.

Patient / Legal Guardian Signature____Date____________
Consent expires one year from date signed

The information contained in this document is legally privileged and confidential information intended only for the use of the individuals or entities named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this message is strictly prohibited. If you have received this message in error, please immediately notify Ayurveda For Life telephone and return the message to us at the below address by US mail.

STATEMENT OF UNDERSTANDING

I understand that Jennifer Carlson is an Ayurvedic Consultant and Educator who provides me with information on the Ayurvedic approach to health care, which may affect my diet and health in a positive way. I understand that Jennifer is not a medical doctor or licensed medical practitioner, has not presented herself such, and does not seek to diagnose, treat or prescribe for disease, disorder or other pathological conditions.

I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought these Ayurvedic consulting services. I agree that I may consult a licensed physician for any concern, at any time, about any disease or pathology, which now exists or arises at any time during my professional relationship with Jennifer.

Furthermore, I understand that Jennifer encourages regular medical checkups from a licensed medical professional of my choice, and that any medication that I am now taking upon my licensed physician's advice, or will take in the future, is taken strictly according to my licensed physician's directions. Furthermore that only a licensed physician of my choice can advise on medication dosages or the discontinuance or resumption of such medication.

I understand and agree that I am ultimately responsible for the cost of any and all professional services rendered by Jennifer Carlson.

Minor children are required to have a parent or legal guardian present at the time of their appointment or no service will be provided and the appointment will be rescheduled. In the case of divorced or separated parents, the parent who brings the child into the office is responsible for any charges.

I authorize Whole Life Health Care, P.A., and its physicians, health care practitioners, employees and the subcontractors in collaboration with Whole Life Health Care, P.A., to have access to my medical records for the purpose of medical treatment/services within the Whole Life Health Care, P.A. facility.

24 hour notice is requested when canceling appointments.

My signature below acknowledges the above statements as fully read and understood.

Client's signature____ Date:____________________

Parent/Guardian signature____ Date:____________________