Client History

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AYURVOLOGY

PLEASE PRINT

Date_____

Name_____ Phone #_____

Email_____ Date of Birth_____

How did you find us?_____

Reason for consultation_____
_____
_____

History of major illness_____
_____
_____

Current medications_____
_____
_____

Occupation_____

Do you enjoy your work?_____

Any other source of stress?
_____

I hereby waive and release Ayurvology LLC from any and all liability, past, present, and future relating to any bodywork and treatments.

Signature_____

Client History

PLEASE PRINT

Name_____

Within the last year, which symptoms have you experienced

VATA	PITTA	KAPHA
O Dryness	O Diarrhea	O Congestion
O Insomnia	O Loose stool	O Dull, vague pain
O Gas	O Nausea	O Edema
O Bloating	O Migraines	O Heaviness
O Constipation	O Vomiting	O Dullness
O Hemorrhoids	O Excess thirst	O Difficulty seating
O Joint Pain, Cracking	O Burning, sharp pain	O Frequent urination
O Stiffness	O Spontaneous bleeding	O Excess oily skin
O Shifting, tearing pain	O Tenderness to touch	O Excess sleep
O Dry cough	O Excess body heat	O Cold, clammy hands
O Restlessness	O Interrupted sleep	O Mental lethargy
O Worry, fear, anxiety	O Bruising	O Depression
O Muscle: twitching, cramping, numbness, weakness	O Anger, rage, envy, judgement, critical	O Food or respiratory allergies
O Goosebumps	O Skin rashes, hives, acne,boils	O Greed, attachment