Nature Veda
Body Mind Beauty

CONFIDENTIAL PATIENT HISTORY

Patient's Name: _____

Patient's Address: _____

City, State, Zip:_____

Telephone Cell: _____ Work: _____Email: _____

Birth date: _____ Birth place: _____ Age: _____

Time of birth: _____ Place of childhood: _____

Marital/partner status: _____ # of children: _____Ages: _____

Occupation: _____ Blood type: _____ Height: _____ Weight: _____

Social Security #_____ Credit Card # _____

How did you hear about Nature Veda? _____

FINANCIAL POLICY AGREEMENT

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1. There is a $995 charge for each Initial Consultation.
2. There is a $255 charge for each (60 minute) follow-up visit.
3. Visits may be paid in Cash, Check or pre-paid via Credit Card only.
4. Your customized program often sometimes incorporates herbal formulas. There is an additional charge for herbal formula design, preparation and shipping.
5. Our office does not bill insurance companies.
6. Payments are due when appointments are scheduled.
7. All appointment cancellations require a 48 hours notice.
8. If you miss your scheduled visit without giving a 48 hour notice or do not show to your appointment, the full amount of your scheduled visit will be billed to your account.
9. I have read and understood all financial policies.

Patient's Signature: _____Date: _____

LIFE IN BALANCE

Ayurvedic Medicine

1. *Intention of Program: To educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. As you begin to move towards balance, you become more conscious and your natural, innate intelligence wakes-up, you begin to naturally make choices that are nurturing, healing, and balancing. You will be educated and empowered to take charge of your own health, and begin to develop the awareness to bring balance and health to each moment of your life, restoring you to your true joyful nature and present to the beauty and magic of life.*

2. *Outline of Services: 1 1/2 hour Consultation; an opportunity to assess your current physical, mental and spiritual routines, your prakruti (fundamental state of balance) and your vikruti (current imbalance). I will begin to educate you on your individual constitution and the basics of Ayurveda. You will be introduced to new practices as part of your plan for achieving balance. Practices may include meditation, yoga, dietary adjustments and breathing exercises all designed to further your education, awareness and ability to bring balance to your life. Consistent 1 hour follow-up sessions will be recommended to monitor and support your progress. In this way you can integrate lifestyle changes over time and we can make any adjustments needed in your program.*

3. *Ayurveda is not about instantaneous results, although you will see many immediate benefits. In accordance with the laws of nature, it will take time to gently restore full balance. Life is dynamic and we are part of life. We continually need to modify our lifestyle to the changing seasons, emotions, stresses etc. to achieve balance. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living. Using the ancient wisdom of Ayurveda I will educate, empower and support you as a dynamic individual, but it is up to you to bring this into your daily life. It is a simple, natural science that takes time, as it takes time for the stream to wear the stone smooth, but gently, over time it changes form completely. It is amazing the difference a small adjustment in your diet or lifestyle can make to create greater well-being. I am excited and honored to assist you in discovering your uniqueness and create a balanced life with radiant health and a peaceful mind.*

Patient Signature: _____

Ayurvedic Practitioner: _____

Please take quiet time and space to answer these questions. Take this as an opportunity to bring awareness to areas of your life that may need more loving attention. Please use a separate sheet of paper if needed.

1. *What are you currently doing in your life that brings you peace, health, balance and/or nurtures your soul?*

2. *What would you like to get out of your Ayurvedic Consultation?*

   a)

   b)

   c)

2. *Where in your health, life, and relationships (to self and others) do you experience a lack of freedom, balance, and joy?*

3. *Which areas in your life are you most interested in bringing balance to?*

4. *If you achieved a perfect state of health, which is balance between your fundamental energies, or "doshas" and your body, mind and soul or consciousness, what would your life look like? How would you feel? What would you be doing? What would be different? Paint a picture for yourself.*

5. *What results do you want to produce in your physical body?*

6. *What results do you want to produce in regards to your mental and emotional well-being? Do you find yourself anxious, stressed, depressed, or easily brought to annoyance or anger?*

7. *What do you want your spiritual life to look like?*

8. *How am I able to best support you in achieving the health, vitality, and balance you want in your life?*

9. *What would you have to give up to have the results you want?*

10. *Where do you go, what does it look like when you get resigned or go down the deep dark tunnel of despair?*

INFORMED CONSENT

to receive Ayurvedic Health Care through
*Ciann Masi Ayurvda/**Nature Veda***

All clients who participate in alternative health care should be advised of the following:

The goal of all 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 using the principles of Ayurveda, Naturopathy and Intuitive Medicine. My mission is to empower and educate individuals to create and take charge of their own health, such that you are energized, joyful and present to the beauty and magic of life.

I, _____, hereby agree to the following:

1. *I am participating in alternative health programs, yoga classes or workshops offered by Ciann Masi/Nature Veda Wellness. During which I will receive information and instruction about alternative health, nutrition and/or yoga. 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 any alternative healthcare programs, yoga classes, or workshops. I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in alternative healthcare programs, yoga classes or workshops.
3. In consideration of being permitted into alternative healthcare programs, yoga classes 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 alternative healthcare programs, yoga classes, and workshops I knowingly, voluntarily, and expressly waive any claim(s) I may have against Ciann Masi/Nature Veda Wellness 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 Ciann Masi/ Nature Veda Wellness for any injury, physical, personal/emotional harm, or death caused by negligence or any other act.
6. Ciann Masi/Nature Veda Wellness is not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
7. Ciann Masi/Nature Veda Wellness is not a Medical Doctor (M.D.).
8. In the United States of America, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003. I state that I come to Ciann Masi/Nature Veda Wellness with the purity of purpose of seeking more information. I state that I do not come with any forethought or desire for entrapping Ciann Masi/Nature Veda Wellness into an illegal statement. If I am a member of the A.M.A., the F.D.A., or any law endorsement agency, or any city, county, state or federal regulatory agency, then I will identify myself as such before the appointment begins.
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. We will not alter your prescriptions without the approval of your Medical Doctor. We may suggest that you speak to your Doctor about reducing medication when we feel 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 or Holistic 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, we 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.

Client's Signature: _____Date: _____

CHIEF HEALTH CONCERNS

What are your main health concerns at this time? Order by importance to client.

PRIMARY CONCERNS	CLINICIAN NOTES
1.	
2.	
3.	
4.	
5.	
6.	

PAST MEDICAL HISTORY

Include major conditions, dates of treatment and procedures performed.

1. Serious illnesses: _____

_____

2. Hospitalizations: _____
3. Operations: _____
4. List other pertinent past conditions: _____

_____

5. Have you been under the care of a licensed health care professional in the past year? ❑**Yes** ❑**No**
If so, for what reasons: _____

6. Is there any possibility that you are pregnant? ❑ Y ❑ N

FAMILY HISTORY PLEASE CHECK THE APPROPRIATE BOXES AND INDICATE FAMILY MEMBER.

❑ Cancer	❑ Diabetes
❑ High Blood Pressure	❑ Heart Disease
❑ Stroke	❑ Mental Disorder
❑ Other (explain)	❑ Other (explain)

CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, supplements are you currently taking?
Please include significant remedies that you have recently stopped taking.

Name of substance:______________________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

Who recommended/prescribed it?______________________________

Purpose of substance:______________________________

How long have you been taking it:______________________________

In what form do you take it (include dosage): ______________________________

How often do you take it? ______________________________

What effects have you noticed?______________________________

Name of substance:______________________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

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In what form do you take it (include dosage): ______________________________

How often do you take it? ______________________________

What effects have you noticed?______________________________

DAILY ROUTINES

To be filled out by patient

DAILY SCHEDULE *(include approximate times)*

1. *Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities).*

	Time	*Activities*	
Morning			*VARIATIONS*
Awaken			
Breakfast			
Activities			
Mid-day			
Lunch			
Activities			
Evening			
Supper			
Activities			
Night			
Activities			
Bed-time			

2. *List regular practices that are not included in the above schedule, e.g., exercise, meditation, spiritual practices, etc.*

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3. *Are you sexually active? Y ❑ N ❑ Frequency?*

4. *Other comments about daily routines:*

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5. *What types of food(s) are eaten on a regular basis?*
BREAKFAST:

LUNCH:

DINNER:

SNACKS:

6. *Are there any routines around eating:*

7. *Any current or past problems with chronic eating disorders or other food related issues?* ❑ ***Y*** ❑ ***N***

ALLERGIES OR SENSITIVITIES

8. *Do you have allergic reactions to any substances? If yes, please list.*

GENERAL HEALTH HABITS

9. *How many cups of caffeinated beverages do you drink per day?*
_____ *Type(s) of beverage: coffee/tea/soda*

10. *How many cups of non-caffeinated beverages do you drink per day? #* _____
Type(s) of beverage: herbal tea/milk/juice/other _____

11. *How much water do you drink per day?*_____

12. *Do you exercise regularly? Y N Length of time:* _____
Times per week: _____*Type(s) of exercise:* _____
_____

13. *If you smoke, how many cigarettes do you smoke per day?* _____*Have you ever smoked? Y N*
Amount/day: _____ *When quit?* _____

14. *If you drink alcohol, how many glasses of alcohol per week?* (Include beer, wine, liqueurs and hard liquor) *#* _____*per week Type(s) of beverage:*_____

15. *Any current or past problems with addiction or substance abuse? Y N*
Substance: _____ *Amount:* _____ *When quit?* _____

16. *Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite):* _____
_____

17. *Body temperature: Do you generally run warm or cold? Please explain:* _____
_____

REVIEW OF SYMPTOMS

Check all symptoms that are of concern to you at this time that you want to discuss with the practitioner. Please indicate any area in which you have experienced a severe episode and indicate if episode was in previous 6 months or prior to 6 months time.

HEAD

Concern	Office	
		Headaches
		Dizziness
		Fainting spells
		Loss of balance
		Difficulty remembering
		Difficulty thinking clearly
		Thinning or loss of hair

EARS

Concern	Office	
		Hearing loss
		Ringing
		Earaches–Pain
		Discharges
		Bleeding

EYES

Concern	Office	
		Pain–soreness in eyes
		Redness
		Burning
		Mucous
		Dryness
		Itching
		Tic/twitch
		Blurred/loss of vision

MOUTH

Concern	Office	
		Excessive thirst
		Loss of taste
		Strange taste
		Bad breath
		Lip ulcers or lesions
		Dry/cracking lips
		Tongue pain
		Bleeding gums
		Receding gums
		Tooth pain
		TMJ

NECK

Concern	Office	
		Pain
		Swollen glands
		Lumps
		Stiffness

CHEST

Concern	Office	
		Pain in chest
		Tightness/pressure in chest
		Heart palpitations
		Shortness of breath
		Painful–difficult breathing

		Persistent cough
		Frequent chest colds

Concern	Office	NOSE
		Loss of smell
		Bleeding
		Pain
		Discharge
		Post-nasal drip
		Sinus Congestion

Concern	Office	SKIN
		Dry–flakey
		Rashes
		Blisters
		Acne
		Changing or bleeding moles
		Response to insect bites

Concern	Office	DIGESTION
		Pain
		Burning indigestion
		Belching
		Regurgitation
		Vomiting
		Excessive Gas
		Heavy–Bloaty after eating
		Hemorrhoids
		Constipation (< 1 BM/ day)
		Diarrhea
		Both constipation & diarrhea
		Bloody Stool

Concern	Office	CIRCULATION
		Varicose veins
		Cold hands–feet
		Swollen ankles
		Calf pain
		Puffy eyes

Concern	Office	URINARY
		Loss of urination control

Concern	Office	FEMALE SYSTEM
		Irregular cycle
		Heavy/prolonged bleeding
		Missed menses
		Painful menses
		Spotting
		Discharge
		PMS symptoms
		Pregnant

		Painful urination
		Urine retention, dribbling
		Daytime urination often
		Nighttime urination often
		Blood in urine
		Pain in kidney/groin area
		Kidney/bladder infections

Concern	Office	MUSCLES&JOINTS
		Swelling in joints
		Pain/ache in joints
		Stiff joints
		Persistent muscle/ bone pains
		Tremors/tics in muscles
		Muscle weakness/ atrophy

Concern	Office	NERVES
		Loss of taste, smell or touch
		Tingling sensations
		Tremors in limbs
		Uncoordinated muscle/ limbs

		Miscarriage
		Infertility
		Genital sores
		Ovarian cyst
		Fibroids

Concern	Office	BREASTS
		Swelling
		Redness
		Lumps
		Nipple discharge
		Tenderness–pain

Concern	Office	MALE SYSTEM
		Prostate gland swollen/ painful
		Low sperm count
		Low motility
		Genital sores or lesions
		Genital discharge
		Erection difficulty