



SAN DIEGO AYURVEDA HEALING

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Client intake

01 / 03

Please complete what you can. Optional questions may be left blank.

01. About you

Date	Full name	Date of birth
Street address	City	State / ZIP
Phone	Email	☐ Text OK
Gender identity (optional - select any that fit)		
☐ Woman	☐ Man	☐ Nonbinary
☐ Transgender	☐ Prefer not to say	
Self describe, if you wish	Emergency contact	Their phone

02. Your visit

What would you most like to discuss? Include when concerns began, if known.

Are you currently receiving care from another professional? Note any recent treatments or therapies.

03. Your context

These questions help us understand your routines and past experience.

☐ I have received Ayurvedic care or Panchakarma before
If so, when, where, and with whom?

Occupation	Work hours / week	How did you hear about us?
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CONFIDENTIAL CLIENT INFORMATION

Bring to your visit or use a return method agreed with the practice. Avoid ordinary email for sensitive details.

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Health history

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Check what applies and add details where helpful. Leave any optional item blank.

04. Personal and family history

Mark "You" or "Family" and add timing or notes in the last column.

Condition	You	Family	Since / notes
Cancer	☐	☐	
Diabetes	☐	☐	
Hepatitis	☐	☐	
Heart disease	☐	☐	
High blood pressure	☐	☐	
Seizures	☐	☐	
Rheumatic fever	☐	☐	
Emotional or mental health	☐	☐	
Infectious disease	☐	☐	
Tuberculosis	☐	☐	

Optional context: household, relationships, children, ancestry, or sexual health history

05. Medications, supplements, and allergies

List prescriptions, over-the-counter medicines, herbs, and supplements; use the reverse if needed.

Item and dose	Reason and duration	Prescriber / last review

Known allergies and reactions (or write "none known")

Please check any that apply:

☐ Warfarin

☐ Lithium

☐ Pacemaker

☐ Diabetes medication

☐ Cholesterol / lipid medication



Daily life and wellbeing

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Your answers help shape a conversation around your circumstances.

06. Daily routine

Height Current weight Weight 6 months ago Weight in early 20s

Use and hydration - mark current or past use, then add frequency or amount.

Item	Current	Past	Frequency / amount
Coffee / tea	☐	☐	
Soda	☐	☐	
Tobacco	☐	☐	
Cannabis / recreational substances	☐	☐	
Alcohol	☐	☐	
Water (glasses per day)			

Eating pattern (select any that apply):

- ☐ Vegetarian ☐ Vegan ☐ Lacto-vegetarian ☐ Gluten-free
☐ Raw ☐ Ayurvedic ☐ Paleo ☐ Ketogenic ☐ Diabetic

Other pattern or food preferences

Exercise - type, frequency, hours / week

Recent feelings or thoughts (optional; select any):

- ☐ Joyful ☐ Peaceful ☐ Calm ☐ Safe ☐ Anxious ☐ Worried
☐ Sad ☐ Angry ☐ Low mood ☐ Prefer not to answer

07. Life areas

Rate each area if you wish; add a note in the last column.

Area	Great	Good	Fair	Needs attention / comments
Significant other	☐	☐	☐	
Family	☐	☐	☐	
Diet	☐	☐	☐	
Sex	☐	☐	☐	
Self	☐	☐	☐	
Work	☐	☐	☐	
Exercise	☐	☐	☐	
Spirituality	☐	☐	☐	