Blossom
Ayurveda & Yoga

Intake Questionnaire

Date: **Date of Birth :**

First Name: _____ _____

Sex Assigned at Birth: _____ Gender Identity: Preferred Pronouns:

Relationship Status: ❑ Married ❑ Single ❑ Divorced ❑ Partnership

Age: _____ **Height:** _____ Ethnicity/Cultural background: _____

Occupation: _____

Please describe your present health concerns and their duration.

Are you currently under the care of a family physician or any other health professional?

❑ Yes ❑ No

If yes, please explain: _____

Are you currently taking any medications and/or receiving any medical treatment for your health condition? If so, please list all medications/treatments and their dosage.

Are you allergic to any substances? Please specify: food, pollen, dust, etc., and any other allergic reactions?

Do you have any past medical history? If yes, please specify the age of occurrence, duration, and its treatment.

HEALTH AS A CHILD

❑ Good ❑ Fair ❑ Poor

How would you rate your usual energy level?

❑ Very high ❑ High ❑ Moderate ❑ Low ❑ Very low

DIGESTION

Do you experience any of the following?

❑ Gas ❑ Heartburn ❑ Low appetite
❑ Bloating ❑ Sour burps ❑ Nausea
❑ Constipation ❑ Diarrhea ❑ Heavy feeling in stomach

BOWEL MOVEMENTS

❑ Once every 2–3 days ❑ Once daily ❑ 2–3 times per day
❑ First thing in the morning ❑ Late in daytime ❑ Immediately after meals
❑ Immediately after dinner ❑ Need laxative daily ❑ Other, please specify: _____

Bowel nature:

❑ Soft ❑ Medium ❑ Hard

Bowel movement associated with:

❑ Pain ❑ Gas ❑ Blood ❑ Mucous
❑ Foul smell ❑ Other: _____

URINATION

Do you have any of the following urinary problems?

❑ Pain ❑ Burning sensation ❑ Discoloration ❑ Frequent urination during the day
❑ Urination several times during the night ❑ Other: _____

NATURAL URGES

Do you delay or suppress any of the following?

❑ Bowel movements ❑ Gas ❑ Urination ❑ Sleep ❑ Yawning ❑ Burping
❑ Breathing ❑ Sneezing ❑ Hunger ❑ Thirst ❑ Semen ❑ Cry, tears

SLEEPING

What time do you go to sleep? _____ **What time do you wake up?** _____

Do you nap during the day?

❑ Yes ❑ No

How do you generally feel when you wake up in the morning?

❑ Fresh and rested ❑ Little tired ❑ Very tired

How is your sleep?

❑ Sound, normal duration
❑ Too heavy and or too long
❑ Wake up too early
❑ Light, interrupted
❑ Difficulty falling asleep
❑ Frequent nightmares
❑ Too little sleep
❑ Difficulty waking up

EMOTIONS

What is your present state of mind and emotions?

❑ Good ❑ Fair ❑ Poor Excellent

Do you often experience any of the following?

❑ Worry ❑ Anxiety ❑ Fear or panic ❑ Loneliness ❑ Depression
❑ High stress level ❑ Lack of memory ❑ Light-headedness ❑ Lack of energy
❑ Anger ❑ Irritation

How are your family relationships?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

How is your social life?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

How is your mental status?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

How is your career?

❑ Love it ❑ Like it ❑ Dislike it

How purposeful is your life?

❑ Completely ❑ Neutral ❑ Not happy

Rate your spiritual life:

❑ Satisfying ❑ Neutral ❑ Empty

DAILY ROUTINE

How regular is your daily routine?

(for example, do you go to bed early, eat your meals on time, exercise regularly, etc.?)

❑ Very regular ❑ Somewhat regular ❑ Irregular

Do you practice any type of yoga or meditation? Please explain.

Do you have a movement practice/exercise? Please explain.

Do you travel a lot?

❑ Yes ❑ No

How often do you smoke cigarettes or marijuana?

❑ Never ❑ Less than once a week ❑ About once a week ❑ Several times a week
❑ More than once a day

How often do you drink alcohol?

❑ Never ❑ Less than once a week ❑ About once a week ❑ Several times a week
❑ More than once a day

How often do you drink caffeinated beverages (coffee, tea, etc.)?

❑ Never ❑ One cup daily ❑ 2–3 cups daily ❑ 4–5 cups daily

Which type of weather makes you feel most uncomfortable? (Choose one)

❑ Cold ❑ Hot ❑ Cool and damp

PHYSICAL BODY

What is your body build?

❑ Thin ❑ Large ❑ Average ❑ Muscular

How often do you exercise? ❑ 3–4 days a week ❑ 5–6 days a week

❑ Once a week ❑ Twice a week
❑ Every day ❑ Not at all

How long do you exercise? _____ **What type of exercise?** _____

Is your exercise: (choose one)

❑ Vigorous ❑ Moderate ❑ Light

FOOD PRACTICES

Food Groups	Daily	Weekly	Monthly	Never
Grains / Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

Please explain what you typically eat for meals.

Breakfast

Lunch

Dinner

Snacks

Do you eat between meals?

❑ Yes ❑ No

Do you eat your meals at the same times daily?

❑ Yes ❑ No

Which is your main meal?

❑ Breakfast ❑ Lunch ❑ Dinner

Rate your digestion:

❑ Good ❑ Fair ❑ Poor

How much water you drink per day?

❑ Never ❑ 1–2 glasses ❑ 3–4 glasses ❑ 5–6 glasses ❑ 7 glasses or more

My eating habits include:

❑ Eat with full attention on food ❑ Talk or converse a lot while eating ❑ Eat very fast
❑ Watch television while eating ❑ Never sit to eat

Describe your diet:

❑ Vegan ❑ Lacto-vegetarian ❑ Ova-lacto-vegetarian
❑ Other, please specify: _____

Non-vegetarian:

❑ Beef ❑ Pork ❑ Chicken ❑ Turkey ❑ Seafood ❑ Eggs
❑ Other, please specify: _____

What taste(s) do you like or crave?

❑ Sweet ❑ Salty ❑ Bitter ❑ Sour ❑ Hot/Spicy ❑ Starches ❑ Oily

Are there any particular foods that create discomfort when you eat them?

❑ Sweet ❑ Sour ❑ Oily/fatty ❑ Hot ❑ Salty ❑ Bitter ❑ Astringent
❑ Dairy products ❑ Other: _____

Age menses began: _____

Which of the following describes your menstruation? (You may choose more than one)

❑ Regular ❑ Irregular ❑ Too frequent ❑ Absent ❑ Ceased due to menopause

How many days does your menstrual period last?

❑ 0–4 days ❑ 5–7 days ❑ More than 7 days ❑ Spotty or irregular throughout the month
❑ Other, please explain: _____

How is your menstrual flow?

❑ Heavy ❑ Light ❑ Normal

Associated symptoms (before or during menstruation):

❑ Food Cravings ❑ Cramping ❑ Fluid retention ❑ Migraine ❑ Depression ❑ Acne
❑ Tension ❑ Anger ❑ Frustration ❑ Breast tenderness ❑ Nightmares
❑ Other, please specify: _____

Do you experience pain during intercourse?

❑ Yes ❑ No

Do you have any sexual difficulties?

❑ Yes ❑ No If yes, please explain: _____

Are you pregnant now?

❑ Yes ❑ No ❑ Don't know

Do you take contraceptive pills or use other forms of birth control?

❑ Yes ❑ No If yes, please explain: _____

Number of previous pregnancies: _____ **How many children do you have?** _____

Do you do breast self-exams regularly?

❑ Yes ❑ No

Do you experience any problems in your breasts?

❑ Lumps ❑ Pain or tenderness ❑ Nipple discharge ❑ Other: _____

HOW TO DETERMINE YOUR CURRENT STATE OF BEING

When answering the following questions, evaluate your current state of being. Circle one description for each row, or two if the answers are close.

Mental Profile

	Vata		Pitta		Kapha	
Mental activity	Quick, active, restless		Sharp, critical, aggressive		Calm, steady, slow, stable	
Memory	Short term		Generally good		Good long term	
Concentration	Weak		Generally good		Very good	
Ability to learn	Quick to grasp concepts		Moderate ability to grasp new information		Slow to grasp new information	

Dreams	Fearful, very active, flying,		Aggressive, fiery, adventurous		Watery, romance, relationships	
Sleep	Light, interrupted		Sound, medium		Sound, heavy, long	
Speech	Quick, can miss words		Sharp, direct, strong		Slower, clear, melodious	
Voice	High pitched		Medium pitched		Low pitched	
Sub-total						

Behavioral Profile

	Vata		Pitta		Kapha	
Eating speed	Fast		Medium		Slow	
Hunger level	Irregular		Sharp, can be strong		Can easily miss meals	
Food/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, low		Moderate		Strong	
Works best	Supervised		Alone		In groups	
Weather preference	Warm and moist		Cool and dry		Warm and dry	
Reaction to stress	Excites quickly		Medium		Slow to get excited	
Financial	Doesn't save, spends quickly		Saves but big spender		Saves regularly, accumulates wealth	
Routine	Dislikes routine		Likes planning and organizing		Works well with routine	
Sub-total						

Emotional Profile

	Vata		Pitta		Kapha	
Moods	Changes quickly		Changes slowly		Steady, unchanging	
Reacts to stress with	Fear		Anger		Indifference	
More sensitive to	Own feelings		Not sensitive		Others feelings	
When threatened tends to	Run		Fight		Make peace	
Relations with spouse/partner	Clingy		Jealous		Secure	
Expresses affections	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	
Sub-total						

Physical Profile

	Vata		Pitta		Kapha	
Amount of hair	Average		Thinning		Thick	
Hair type	Dry, frizzy, thin, dark		Straight, fine, premature graying		Oily, wavy, thick	
Hair color	Light brown, blond		Auburn, reddish		Dark brown, black	
Skin	Dry, rough or both, dark/sallow, tans easily, cold		Soft, normal to oily, light, sunburns easily, warm		Oily, moist, fair, thic, cool	
Complexion	Darker		Pink, red		Pale/white	
Eyes	Small, brown, gray, violet, unusual color		Medium, green, hazel, almond-shaped		Large, dark, blue	
Whites of eyes	Blue/brown		Yellow or red		Glossy/white	

Teeth	Very large or very small		Small -medium		Medium-large	
Weight	Thin, hard to gain		Medium		Heavy, easy to gain	
Elimination	Dry, hard, thin, easily constipated		Many during day, soft to normal		Heavy, slow, thick, regular	
Sweat	Scanty		Profuse		Moderate	
Sub-total						

Total	Vata		Pitta		Kapha	

STATEMENT OF UNDERSTANDING AND DISCLOSURE AUTHORIZATION FORM

I understand that Ginger is NOT a licensed medical practitioner, she has not presented herself as such and does not seek to diagnose, treat or prescribe for diseases, disorders or other pathological conditions. I agree that I am interested in enhancing my own abilities to regain balance and establish health in the mind and body, and this is the reason I have sought her Ayurvedic services. I agree that I may consult a licensed physician or practitioner for any concern, at any time, about any disease or pathology, which now exists or arises at any time during my professional relationship with Ginger. I understand that Ginger 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. I also understand that only a licensed physician of my choice can advise on medication dosages or the discontinuance or resumption of such medication.

Blossom Ayurveda & Yoga is a complimentary Ayurvedic holistic wellness counseling business designed to be informative, educative, and supportive of establishing a balance of health within body-mind-spirit, through the maintenance of health and prevention of imbalances. None of the information, treatments, or products are intended to diagnose, treat, cure or prevent any disease. For medical concerns or before making changes to your diet or lifestyle, please consult your physician.

Please DO NOT take Blossom Ayurveda & Yoga as a means to substitute your medical treatment. Ayurveda therapy is a long-term, slow-acting therapy that includes diet, lifestyle changes along with stress management with Ayurvedic bodywork, yoga, and meditation practices. It is a therapy that slowly builds immunity introducing healthy habits for improvement of health and helps to prevent the risk of imbalances such as chronic diseases. It is not an alternative plan for medical treatment. Please call your physician, medical facility, or emergency services for ALL medical complaints.

Blossom Ayurveda & Yoga is not a yoga studio. Private sessions of yoga and Abhyanga instruction (Ayurvedic self-massage with external application of oil) are provided as a physical exercise plan and detoxifying stress management tool respectively to support an Ayurvedic lifestyle.

What Ginger can do:

- **Educate clients, members, students on Ayurvedic diet and lifestyle practices.**
- ***Recommend natural products, formulations, and supplements.**
- **Provide education on Ayurvedic knowledge and perspectives on health and traditional perspectives on dysfunction.**
- **Provide education and suggestions on health improvement and general traditional techniques according to Ayurveda.**
- **Improve, support, and promote health and its functions.**
- **Educate on how to make better choices for positive health and quality of life.**

I sign below to indicate that I have carefully read and understand the above terms, which I accept in their entirety and without reservation.

Signature: _____ Date: _____

Print First Name: _____