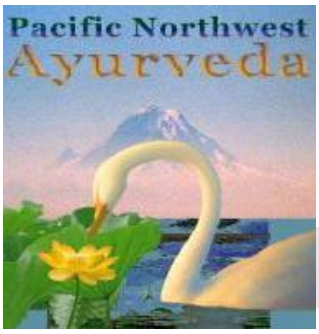

Name: _____
Age today: _____
DOB: _____ Today's Date: _____

AYURVEDIC GUIDED CLEANSE INTAKE MEDICAL FORM

Submit via email to trishfoss@gmail.com or mail to the address below

Demographics			
Name:			
Address:	City	State	Zip
Contact info: Please check preferred contact method. ❒ Phone: ❒ Email:			
Emergency contact: Name: Phone: Relationship:			

Current Health Status	
Why are you interested in doing this Ayurvedic Guided Cleanse?	
Any chance you are pregnant or becoming pregnant in January? ❒ YES ❒ NO **NOT an appropriate **Are you currently being treated for cancer or other deep disease? ❒ YES ❒ NO time to cleanse.**	
Please rate your overall level of health: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Please rate your overall level of energy: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Please rate your overall level of stress: (Low) 1 2 3 4 5 6 7 8 9 10 (High)	
Marital status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Partnered Children & ages: _____	
Occupation:	Education (last grade completed):

Ayurvedic/Medical History	
Place of birth (city, state):	Date & time of birth (if known):
Do you know your Ayurvedic constitution? If so, please list here:	
How close are you to your ideal health? (Far) 1 2 3 4 5 6 7 8 9 10 (Close) Were you sick as a child? (Sick) 1 2 3 4 5 6 7 8 9 10 (Well)	
Do you have a daily routine? ❒ Yes ❒ No ❒ Sometimes What do you do for stress reduction?	
Are you currently under the care of a medical provider for a specific medical condition? ❒ Yes ❒ No If so, for what? _____ Name & contact info for provider:	
Please list any medical conditions diagnosed (ex: high blood pressure) or not (ex: heartburn). Place a STAR next to any conditions that are *current concerns.* 1. 2. 3.	

Name:_____ DOB: _____

4.

Please check any boxes that apply to you personally or your family							
	Myself	Family Member			Myself	Family Member	
		Maternal	Paternal			Maternal	Paternal
Allergies to Food	☐	☐	☐	Stroke	☐	☐	☐
Allergies to Drugs	☐	☐	☐	Cerebro Vascular Accident	☐	☐	☐
Dental Treatment Complications	☐	☐	☐	Cancer	☐	☐	☐
Bleeding Gums	☐	☐	☐	Chemotherapy	☐	☐	☐
Contact Lenses	☐	☐	☐	Radiation Treatment	☐	☐	☐
Glaucoma	☐	☐	☐	Hepatitis A	☐	☐	☐
Eye Surgery	☐	☐	☐	Hepatitis B	☐	☐	☐
Pain in the Ear	☐	☐	☐	Hepatitis Non-A / Non-B	☐	☐	☐
Ringing in the Ear	☐	☐	☐	Mononucleosis	☐	☐	☐
Shortness of Breath	☐	☐	☐	Jaundice	☐	☐	☐
Asthma	☐	☐	☐	Anemia	☐	☐	☐
Pneumonia	☐	☐	☐	Gallstone	☐	☐	☐
TB	☐	☐	☐	Kidney Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐	Kidney Stones	☐	☐	☐
Low Blood Pressure	☐	☐	☐	Bladder Disease	☐	☐	☐
Dizziness	☐	☐	☐	Thyroid Condition	☐	☐	☐
Fainting	☐	☐	☐	Thyroid Medication	☐	☐	☐
Seizures	☐	☐	☐	Ulcers	☐	☐	☐
Convulsions	☐	☐	☐	Intestinal Bleeding	☐	☐	☐
Epilepsy	☐	☐	☐	Chronic Constipation	☐	☐	☐
Diabetes	☐	☐	☐	Recurring Diarrhea	☐	☐	☐
Feet or Ankles Swelling	☐	☐	☐	Arthritis	☐	☐	☐
Chest Pain	☐	☐	☐	Implant	☐	☐	☐
Angina	☐	☐	☐	Prosthesis	☐	☐	☐
Heart Murmur	☐	☐	☐	Prolonged Bleeding When Cut	☐	☐	☐
Heart Attack	☐	☐	☐	Psychiatric Treatment	☐	☐	☐
Heart Disease	☐	☐	☐	Venereal Diseases (STDs)	☐	☐	☐
Heart Surgery	☐	☐	☐	HIV Exposure	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Sleep Disorders	☐	☐	☐

Please list any medication(s)/supplement(s) you are currently taking (dose, for how long?):

Are you taking any blood thinners (coumadin, warfarin, etc)? ❒ Yes ❒ No

1.

2.

3.

4.

5.

6.

7.

8.

Name:_____ DOB: _____

Is there anything else we should know or you'd like to share with us about your health, your interest or any concerns you have regarding participating in an Ayurvedic cleanse?