

## Ayurvedic Health Questioner & Assessment – (10 pages)

**TODAY'S DATE:** \_\_\_\_\_, 20\_\_\_\_

### PERSONAL INFORMATION

Full Name: \_\_\_\_\_ City/State: \_\_\_\_\_

Age: \_\_\_\_\_, ☐ Male, ☐ Female

**Address:** Street: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Phone number(s)** (cell/direct): \_\_\_\_\_, ☐ text OK.

**Email address:** \_\_\_\_\_

**Contact me by:** Cell best: ☐, Email best: ☐, Text: ☐ OK.

**Please complete this questionnaire as thoroughly as possible.**

Where did you hear about Khabir? \_\_\_\_\_

**What are your major health concerns?**

When did these conditions begin and what have you done to address these conditions?

### PERSONAL HEALTH

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ weight 1 year ago: \_\_\_\_\_, weight in your 20's: \_\_\_\_\_, highest weight: \_\_\_\_\_

Do you follow a **specific diet**? ☐ vegetarian, ☐ vegan, ☐ raw, ☐ lacto-vegetarian, ☐ diabetic, ☐ blood type diet,

☐ Ayurvedic, ☐ gluten free, ☐ Paleo ☐ Other: \_\_\_\_\_

**Do you exercise regularly?** ☐ No, ☐ Yes, if yes: frequency? \_\_\_\_\_ times/week, duration of use? \_\_\_\_\_ no. of years,

Type of exercise and other details: \_\_\_\_\_

**What feelings do you most often experience?** ☐ peace, ☐ joy, ☐ happiness, ☐ anger, ☐ sadness, ☐ fear, ☐ anxiety,

☐ worry, ☐ depression, other: ☐ \_\_\_\_\_

### EATING HABITS

**Cravings:** ☐ sweets, ☐ coffee, ☐ cola, ☐ salt, ☐ hot spices, ☐ chocolate, ☐ fats, ☐ starches/breads, ☐ crunchy

**How many snacks do you have between meals?** ☐ 1, ☐ 2, ☐ 3 or more, ☐ have snacks at night.

**What snacks do you have?** ☐ candy, ☐ cookies, ☐ bread, ☐ chocolate, ☐ cheese, ☐ crackers or chips, ☐ ice cream, ☐ soda, ☐ fruit, ☐ veggies, ☐ protein bars, ☐ nuts, ☐ fruit smoothie, ☐ veggie juice, ☐ \_\_\_\_\_

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**\*\*IMPORTANT: Answer questions based on your whole adult life, not just recently. Try to make one choice per row.\*\***

Vata Type	Pitta Type	Kapha Type
<i>Most of my life . . .</i>		
<input type="checkbox"/> I usually have to eat but I can often forget to eat.	<input type="checkbox"/> I have a strong appetite and I don't generally miss meals	<input type="checkbox"/> I like to eat but I can go without eating or skip meals without discomfort
<input type="checkbox"/> If I miss a meal, I often get light headed, anxious or spacey.	<input type="checkbox"/> If I miss a meal, I often get irritable or even angry easy.	<input type="checkbox"/> If I miss a meal, it does not really bother me.
<input type="checkbox"/> I prefer to eat frequent meals with no set time.	<input type="checkbox"/> I prefer to eat 3 meals a day at the same time and don't usually skip meals.	<input type="checkbox"/> I do fine with 3 or even 2 meals a day and can go without eating easily.
<input type="checkbox"/> After eating, I often experience gas or bloating. Especially with: <input type="checkbox"/> most beans, <input type="checkbox"/> cabbage, <input type="checkbox"/> broccoli, <input type="checkbox"/> salads, <input type="checkbox"/> milk, <input type="checkbox"/> wheat, <input type="checkbox"/> Other: _____	<input type="checkbox"/> After eating, I often experience heartburn or acidity. Especially with: <input type="checkbox"/> hot spices, <input type="checkbox"/> oily foods, <input type="checkbox"/> fried foods, <input type="checkbox"/> onions, <input type="checkbox"/> garlic, <input type="checkbox"/> vinegar, <input type="checkbox"/> tomatoes, <input type="checkbox"/> citrus fruit. <input type="checkbox"/> Other: _____	<input type="checkbox"/> After eating, I often feel heavy, sleepy or congested. Especially with: <input type="checkbox"/> milk, <input type="checkbox"/> bread/wheat, <input type="checkbox"/> cheese, <input type="checkbox"/> yogurt, <input type="checkbox"/> oily foods, <input type="checkbox"/> Other: _____
<input type="checkbox"/> I tend to get or can easily be <u>constipated</u> or have <u>dry stools</u>	<input type="checkbox"/> I tend to have 2 or more bowel movements per day but sometimes they are loose	<input type="checkbox"/> I generally just have 1 well formed bowl movement per day
<input type="checkbox"/> I usually don't gain weight very easy	<input type="checkbox"/> When I gain weight, I can easily lose it.	<input type="checkbox"/> I <u>gain weight easily</u> and lose it slowly.
<input type="checkbox"/> I was thin (before bearing children etc.)	<input type="checkbox"/> I am generally muscular or athletic	<input type="checkbox"/> I am heavy, full bodied or over weight.
<input type="checkbox"/> I can <u>get cold easily</u> and prefer warm weather.	<input type="checkbox"/> I can get <u>warm</u> and even hot easily.	<input type="checkbox"/> I can adapt to most weather but tend to be cold or cool (not warm).
<input type="checkbox"/> My skin tends to be dry, <input type="checkbox"/> itchy or <input type="checkbox"/> with blackheads	<input type="checkbox"/> My skin tends to red with <input type="checkbox"/> burning or <input type="checkbox"/> with a rash	<input type="checkbox"/> My skin tends to be oily with <input type="checkbox"/> white pimples
<input type="checkbox"/> I tend to sleep lightly and awake very easily. <input type="checkbox"/> I often can't get to sleep.	<input type="checkbox"/> I tend to sleep soundly and awake with ease. <input type="checkbox"/> I often wake-up in the night.	<input type="checkbox"/> Get to sleep easily. <input type="checkbox"/> It can be difficult for me to get up in the morning.

### ADDITIONAL CONCERNS

**Do you have a lot of stress in your life?** ☐ Low, ☐ medium, ☐ high, ☐ from work, ☐ from family, ☐ from health.  
How long have you been having this stress? \_\_\_\_/years. How do you deal with stress? Please describe.

**Energy:** Do you: ☐ feel groggy in morning, ☐ wake up feeling refreshed. Need coffee in the ☐ morning, ☐ afternoon, ☐ evening? Do you: ☐ take naps, ☐ get sleepy in the day, ☐ feel fatigued later in day, ☐ feel exhausted at end of the day, ☐ get a "second wind" of energy in the evening. Details and any products used for energy:

**Do you have any body pain?** ☐ Yes, if so 1-10, Neck \_\_\_\_, lower back \_\_\_\_, shoulder \_\_\_\_, joints \_\_\_\_, hips \_\_\_\_, Sharp headache: \_\_\_\_ Dull headache: \_\_\_\_ other: \_\_\_\_

**Women:** Do you still have menstruation? ☐ yes. If yes, what was the last date: \_\_\_\_\_. Have you had menopause? ☐ yes. If yes, when was the approximate date of your last period? \_\_\_\_\_.

Have you taken antibiotics recently? ☐ yes. When did you last have antibiotics? \_\_\_\_\_

Other recent operations or medication? \_\_\_\_\_

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- What would you like to change in regard to your personal health-care at this time in your life?
- 
- What is your present level of commitment to address make changes to your **behavior and lifestyle habits**?  
*Rate from 0 to 10, with 10 being 100% committed: \_\_\_\_\_*
  - What behaviors or habits do you currently engage in regularly that you believe support your health?
- 
- What behaviors or habits do you currently engage in regularly that you believe are self-destructive?
- 
- What is your present level of commitment to address make changes to your **eating habits and diet**?  
*Rate from 0 to 10, with 10 being 100% committed: \_\_\_\_\_*
  - What potential obstacles do you foresee in addressing the dietary and lifestyle factors that are undermining your health?
- 

**Any additional comments or information:**

### **Informed Consent**

It is clearly understood that Khabir Southwick is not a physician, psychologist, psychotherapist or a licensed dietitian. I am voluntarily requesting lifestyle consulting, nutritional counseling, dietary guidelines, supplement recommendations and health consulting based on Ayurvedic principles. I take full personal responsibility for how I choose to interpret and implement all information and recommendations provided.

### **Waiver of Liability**

I, the undersigned, release Khabir Southwick from all liability for any incidental or consequential damages whether physical, mental or practical, resulting from advice, recommendations, herbs, teas, products or treatments provided or recommended.

I understand the importance of regular appointments to revise and complete the treatments and changes recommended.

**Print name:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

*Note: All case history notes and medical information recorded during the consultation are kept strictly confidential. Information contained herein will not be released to any person or agency except with your authorization or where required by law.*

**I am** ☐ a new client, ☐ a returning client, ☐ a prospective client, ☐ wanting to schedule an appointment,  
☐ interested in feedback from this Ayurveda Health Questioner.