

***Disclosure/Consent***

I \_\_\_\_\_, request that Kristina Berkeley provide a holistic health consultation, during which she will examine aspects of my diet and lifestyle.

I give her permission to examine my tongue and pulse as means of analysis.

Holistic care emphasizes prevention. It utilizes diet, herbs and lifestyle as the main means for maintaining good health. Please understand that this consultation will provide information to make changes in the above mentioned areas, however will not include medical advice.

I understand that natural health care is not intended as a substitute for regular medical or mental healthcare.

I understand that Kristina Berkeley has been certified as an Ayurvedic Practitioner and Clinical Herbalist but is not licensed to diagnose, prescribe for, or treat any disease or condition I may have.

---

Signature

Date

***Client Intake Form***  
***Kristina Berkeley, Certified Ayurvedic Practitioner & Clinical Herbalist***

Ayurveda and Herbal Medicine are holistic sciences that utilize a variety of methods for understanding an individual's current state of health.

These include but are not limited to; Observation (examination of skin, eyes, tongue, etc.), pulse taking and questioning.

By answering the following questions in as much detail as possible you are helping me to better make sense of your constitution, or dosha, and current state of health.

Thank you for your interest in Ayurveda, Herbs, and your health!

***Personal Information***

Name\_\_\_\_\_ Today's Date\_\_\_\_\_

Age\_\_\_\_\_ Date of Birth\_\_\_\_\_

Address\_\_\_\_\_

Phone: Home\_\_\_\_\_ Other\_\_\_\_\_

Best time to be reached\_\_\_\_\_

Is it ok to leave you a message at either or both of these numbers?\_\_\_\_\_

Occupation\_\_\_\_\_ Average hours worked per week\_\_\_\_\_

Relationship status\_\_\_\_\_

***Current Health Status & Medical History***

Do you have any present concerns regarding your health? If yes, for how long have you had these concerns?

Have you been seen by other practitioners for this concern and/or received any diagnosis?

Please list any major illnesses or hospitalizations.

Please list any diseases that run in your family.

Please list any medications you are taking and what you are taking them for. Include any herbal supplements and/or vitamins that you take regularly.

In the following sections please mark conditions with a *C* for a current issue you are experiencing, *P* for any past complaint you have experienced and *?* if you are unsure. If you check *Other* please explain in brief.

***Digestion***

Number of bowel movements in an average day\_\_\_\_\_

\_\_\_Excessive appetite \_\_\_Lack of appetite

\_\_\_Low blood sugar \_\_\_IBS

\_\_\_Indigestion \_\_\_parasites

\_\_\_Heartburn \_\_\_Gas

\_\_\_Bloating \_\_\_Hemorrhoids

\_\_\_Acid reflux \_\_\_Nausea

\_\_\_Gallstones \_\_\_Ulcer

\_\_\_Constipation \_\_\_Diarrhea

\_\_\_Other

What foods do you typically eat for the following meals?

Breakfast\_\_\_\_\_

Lunch\_\_\_\_\_

Dinner\_\_\_\_\_

Snacks\_\_\_\_\_

Do you follow any particular diet?

Do you eat regular meals? Do you ever forget to eat? Do you like to snack or eat small frequent meals?

Please circle the tastes you crave the most:

Sweet Salty Spicy Bitter Astringent Sour

Do you prefer hot or cold beverages? Do you drink with meals?

### ***Respiratory***

Number of colds/flu you've had this year\_\_\_\_\_

\_\_\_ Hay fever/allergies \_\_\_ Thick phlegm

\_\_\_ Asthma \_\_\_ Shortness of breath

\_\_\_ Cough \_\_\_ Runny nose

\_\_\_ Bronchitis \_\_\_ Pneumonia

\_\_\_ Other

Do you smoke cigarettes?

### ***Cardiovascular***

\_\_\_ Cold hands and feet \_\_\_ Varicose veins

\_\_\_ High blood pressure \_\_\_ Dizziness

\_\_\_ Low blood pressure \_\_\_ Tightness in chest

\_\_\_ Heart palpitations \_\_\_ Other

### ***Head, Eyes, Ears, Nose & Throat***

\_\_\_ Poor vision \_\_\_ Sinusitis

\_\_\_ Blurry vision \_\_\_ Ear infections

\_\_\_Headaches \_\_\_Ringing in the ears

\_\_\_Congestion \_\_\_Sore throat

\_\_\_Swollen glands \_\_\_Other

### ***Skin and Hair***

\_\_\_Dry skin and hair \_\_\_Dandruff

\_\_\_Oily skin and hair \_\_\_Acne

\_\_\_Rashes \_\_\_Excessive sweating

\_\_\_Itching \_\_\_Eczema

\_\_\_Psoriasis \_\_\_Other

### ***Urinary Tract***

\_\_\_Urinary tract infections \_\_\_Difficult urination

\_\_\_Kidney infections \_\_\_Water retention

\_\_\_Kidney stones \_\_\_Painful urination

\_\_\_frequent urge to urinate

\_\_\_Other

### ***Musculoskeletal***

\_\_\_Muscle cramps \_\_\_Stiffness in muscles and joints\_\_\_

\_\_\_Muscle pain \_\_\_Muscle spasms

\_\_\_Painful joints \_\_\_Muscle weakness

\_\_\_Back pain \_\_\_Other

***Nervous System***

Average hours of sleep a night \_\_\_\_\_

\_\_\_Insomnia \_\_\_Nerve pain

\_\_\_Poor quality of sleep \_\_\_Shingles

\_\_\_Trouble falling asleep \_\_\_Anxiety

\_\_\_Trouble staying asleep \_\_\_Stress

\_\_\_Depression \_\_\_Numbness or tingling

\_\_\_Memory loss \_\_\_Headaches

\_\_\_Obsessive thinking \_\_\_Other

***Reproductive System***

Are you currently sexually active?

\_\_\_STD's

\_\_\_Excessive sex drive

\_\_\_Lack of sex drive

***Female***

\_\_\_Breast pain \_\_\_Pain with intercourse

\_\_\_Infertility \_\_\_Vaginal discharge

\_\_\_Pregnancy \_\_\_Yeast infection

\_\_\_Miscarriage \_\_\_Vaginal dryness

\_\_\_Abortion \_\_\_Other

*Menstruation*

Average length of cycle\_\_\_\_\_

Duration of bleeding\_\_\_\_\_

\_\_\_Acne \_\_\_Heavy flow

\_\_\_Bloating \_\_\_Scanty flow

\_\_\_Mood swings \_\_\_Painful periods

\_\_\_Irregular cycle \_\_\_Other

*Menopause*

\_\_\_Hot flashes \_\_\_Change in libido

\_\_\_Mood swings \_\_\_Night sweats

\_\_\_Vaginal dryness \_\_\_Depression

\_\_\_Osteoporosis \_\_\_Hormone replacement therapy

\_\_\_Other

*Male*

\_\_\_Painful intercourse \_\_\_Painful/swollen testes

\_\_\_Dribbling urine \_\_\_Erectile dysfunction

\_\_\_Prostate pain \_\_\_Penile discharge

\_\_\_Other

## *Lifestyle*

How regular is your daily routine?

Do you engage in regular exercise? If so, what type and how often?

How is your physical endurance/stamina?

Do you lead an active life? Quiet? Do you prefer to be alone or with others?

What behaviors or lifestyle habits do you currently engage in that you believe support your health?

What behaviors or lifestyle habits do you currently engage in that you believe are destructive/unhealthy?

Do you have anything else that you believe relates to your health that you would like to share?