PULSE OF AYURVED CLINIC

CLINICAL AYURVEDIC SPECIALIST

Appointment Date & Time: ____ /____ /____ _____ Practitioner Name: _____

Name:_____

Address:_____

City, State, Zip:_____

Telephone_____Home: _____Cell:_____Work: _____

E-mail: _____Birthdate:_____ Age: _____

Marital/partner status:_____ # of children: _____Ages: _____

Occupation: _____

How did you hear about the Pulse of Life HealthCare Ayurveda Center?_____

_____

Please tell us why you have chosen to have an Ayurvedic Consultation: _____

_____

FINANCIAL POLICY AGREEMENT

1. There is a $195 charge for each initial consultation with a Clinical Ayurvedic Specialist (CAS). This includes the initial consultation and a report of findings in the meeting.....
2. There is $95 charge for each follow-up visit with a CAS.....
3. Your customized program often incorporates herbal formulas. There is a charge for herbal formula design, preparation and shipping (if needed). The CAS will order all herbal formulas on your behalf.....
4. Payment for herbs and consultations may be made by major credit card or check, payable to clinic. The clinic does not provide monthly billing services.....
5. The Clinic does not bill insurance companies for services or herbs.....
6. If Pancha Karma services are recommended and provided at the pulse of life clinic, payment for those services is made through the clinic when the appointments are scheduled.....
7. I have read and understood the financial policies of the Pulse of Life Health Care clinic.....

Patient's Signature: _____ Date: _____

Patient Name_____

INFORMED CONSENT

To Authorize Complementary or Alternative Health Care Through The

PULSE OF AYURVED CLINIC

All Patients who participate in Ayurvedic health care through this program should be advised of the following information:

1. The Pulse of life is not a Medical Clinic.
2. Clinical Ayurvedic Specialists (CAS) with Pulse of Life are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
3. Doctor of Ayurveda is a Chiropractor and a specialist in Ayurvedic medicine and Yoga Therapeutic massage
4. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003.
5. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If your CAS refers you to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
6. Neither your CAS nor anyone in association with the Pulse of Life clinic may recommend altering your prescriptions without the approval of your medical doctor. Your CAS may suggest that you speak to your doctor about reducing medication when he/she feels that it is appropriate.
7. While your CAS may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, the findings will be evaluated from an Ayurvedic perspective only and not from a Western medical perspective. This examination does not take the place of a medical evaluation. If, as a result of the examination any findings suggestive of a possible medical imbalance is found, your CAS will refer you to a Medical Doctor for further evaluation.
8. By signing below, you give your permission to the California College of Ayurveda to use the information in your chart for research purposes. (NOTE: No patient names, addresses, phone numbers, or email addresses are included in the research records.)

I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with a CAS at the Pulse of Life Health care center.

Patient's Signature: _____Date: _____

Patient Name:_____

CONFIDENTIAL PATIENT HISTORY

PULSE OF LIFE AYURVED CLINIC

WHAT YOU CAN EXPECT FROM YOUR VIISIT

Ayurveda is a natural healing system that has been successfully practiced for thousands of years. Originating in ancient India, this medical tradition states that each person's path toward optimal health is unique because each person is unique. The healing programs we offer at Pulse of Life Clinic are based on effective, time-honored principles which focus on understanding your particular body-mind constitution and the unique nature of your imbalance.

Each individualized program is formulated by a graduate who has completed at least 600 hours of instruction at the Pulse of Life, and has completed advanced training as a Clinical Ayurvedic Specialist. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other natural therapeutics. In order to successfully implement these Ayurvedic principles into your life, frequent regular follow-up visits with your CAS are recommended over a six- to twelve-month period.

The goal of all Ayurvedic programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.

Patient's Signature:_____ Today's Date: _______________

CAS Name:_____
Initial Appointment_____ ROF Date: _____

(1) PAST MEDICAL HISTORY

Include major conditions and dates of treatment and procedures performed

a. Serious illnesses: _____

_____

b. Hospitalization:_____

c. Operations: _____

d. List other pertinent past conditions:_____

_____

e. Have you been under the care of a licensed health care professional in the past year?

☐ Yes ☐ No

If so, for what reasons _____

f. Have you had any cosmetic surgery or procedures performed? Yes ☐ No ☐

If so, please list with dates:

_____

_____

Patient Name: _____

(2) FAMILY HISTORY

Indicate what members of your immediate family have had these conditions. (Go back one generation)
(If adopted, answer according to family heritage, if known.)

❑ High Blood Pressure _____ ❑ Heart Disease _____ ❑ Other _____

❑ Cancer _____ ❑ Mental Disorder _____ _____

❑ Stroke _____ ❑ Diabetes _____ _____

(3) ALCOHOL, TOBACCO AND SUBSTANCE USE

	PRACTITIONER NOTES:
a. Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how often: ❑ *Daily* ❑ *Several times weekly* ❑ *Several times monthly* ❑ *Seldom* I usually choose: ❑ beer ❑ wine ❑ sweet or hard liquor	
b. Have you ever smoked tobacco? ❑ Yes ❑ No If yes, how much per day?_____ If you have quit smoking, when did you quit? _____	
c. Any current or past use of addictive or habitual substances? ❑ Yes ❑ No ***(Note: This will be kept confidential)*** Please list all substances (either current or long-term past usage):_____ _____ _____	

(4) REGULAR PRACTICES

❑ EXERCISE/HATHA YOGA *(Specify)*	❑ *None/Never*	❑ *Occasional*	❑ *Several times per week*
		❑ *Daily*	❑ *Several times per month*
❑ TEAM SPORTS/RECREATION *(Specify)*	❑ *None/Never*	❑ *Occasional*	❑ *Several times per week*
		❑ *Daily*	❑ *Several times per month*
❑ TRAVEL *(Include commute if applicable)*	❑ *None/Never*	❑ *Occasional*	❑ *Several times per week*
		❑ *Daily*	❑ *Several times per month*
❑ SPIRITUAL PRACTICES *(Specify)*	❑ *None/Never*	❑ *Occasional*	❑ *Several times per week*
		❑ *Daily*	❑ *Several times per month*
❑ MEDITATION/PRAYER/PRANAYAMA *(Specify)*	❑ *None/Never*	❑ *Occasional*	❑ *Several times per week*
		❑ *Daily*	❑ *Several times per month*
❑ OTHER *(Include creative activities)*	❑ *None/Never*	❑ *Occasional*	❑ *Several times per week*
		❑ *Daily*	❑ *Several times per month*

(5) SEXUAL ACTIVITY

According to Ayurveda, a person's level of sexual activity impacts health and well-being in the same way as other aspects of daily life--such as diet or sleep.

a. How often do you engage in sexual activity (include sex with partner and masturbation):

❑ *Daily* ❑ *Several times per week* ❑ *Several times per month* ❑ *Occasionally* ❑ *Not at all*

b. Is your current sexual activity satisfactory? ❑ *Yes* ❑ *No*

(6) FOOD CHOICES

What types of foods do you eat on a regular basis?

BREAKFAST: Time:

LUNCH: Time:

DINNER: Time:

SNACKS: Time:

(7) DAILY LIQUID INTAKE *(Indicate number of 8 ounce cups per day)*

❑ Plain water _____

❑ Caffeinated Coffee/Tea _____ ❑ Herbal Tea or Juice_____ ❑ Cow or Goat Milk _____

❑ Decaffeinated Coffee/Tea _____ ❑ Soda or soda pop _____ ❑ Grain/nut/soy milk _____

(8) HABITUAL EATING PATTERNS

Describe any current or past eating patterns or any other food related issues.

(9) DAILY SCHEDULE *(include approximate times)*

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

		TIME	HABITUAL ACTIVITIES	INTERN NOTES
MORNING	***Wakeup***			
	Breakfast			
	Activities			
DAY	**Lunch**			
	Activities			
NIGHT	**Dinner**			
	Activities			
	Bed-time			

(10) ALLERGIES OR SENSITIVITIES

Do you have allergic reactions to any substances (including food, pollens, medicines)? If yes, please list.

(11) CHALLENGING PATTERNS

Please indicate any physical and emotional patterns that *you find challenging* by assigning a ***Frequency*** (a number from 1 to 3) and ***Intensity*** (a number from 1 to 10):

FREQUENCY	INTENSITY
1 = DAILY	1 TO 3 = MILD DISCOMFORT
2 = SEVERAL TIMES WEEKLY	4 TO 6 = MODERATE DISCOMFORT
3 = SEVERAL TIMES MONTHLY	7 TO 10 = SEVERE DISCOMFORT

A. DIGESTION

	Frequency 1-3	Intensity 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

B. ELIMINATION

	Frequency 1-3	Intensity 1-10
Constipation (less than 1 BM/day)		
Alternating constipation & diarrhea		
Food particles in stool		
Diarrhea		
Rectal pain or hemorrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

C. EMOTIONS

	Frequency 1-3	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

(12) ADDITIONAL SYMPTOMS OF CONCERN

	Frequency 1-3	Intensity 1-10

(13) PREVIOUSLY DIAGNOSED CURRENT CONDITIONS

	PRACTITIONER NOTES *Please describe symptoms of diagnosed condition*

(14) AYURVEDIC HISTORY

For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to your practitioner about this please check (√) in the column to the right.

CATEGORY				√	PRACTITIONER USE ONLY
Appetite	My hunger level is variable, and I often forget to eat. ☐	I have a strong appetite and don't like to miss meals. ☐	I like to eat, but I can go without eating with no discomfort. ☐		
Appetite	If I miss a meal, I often get light-headed, anxious or cranky. ☐	If I miss a meal, I often get irritable or angry. ☐	If I miss a meal, it doesn't really bother me. ☐		
Appetite	I prefer to eat frequently with no set schedule, but I often forget to eat. ☐	I prefer to eat 3 meals a day at about the same time each day. I rarely skip meals. ☐	I prefer to eat 2 to 3 times daily, but can go without eating. ☐		
Digestion	After eating, I often experience gas or bloating. ☐	After eating, I often experience heartburn or acidity. ☐	After eating, I often feel heavy or sleepy. ☐		
Elimination	I tend to have irregular bowel movements one time per day or less. ☐	I tend to have 1 to 2 bowel movements daily, usually with regularity and ease. ☐	I tend to have one bowel movement per day with no straining or difficulty. ☐		
Elimination	My bowel movements are often dry and hard. At times I may strain or push. ☐	My bowel movements are usually well-formed, but sometimes they are loose and may burn. ☐	My bowel movements are usually well-formed, slow and easy. ☐		
Weight	I usually don't gain weight very easily. ☐	When I gain weight, it is fairly easy to lose it. ☐	I gain weight easily and lose it slowly. ☐		
Body Temperature	My hands and feet often feel cold, and I prefer warmer climates. ☐	I am warm most of the time no matter what the climate is. ☐	I adapt easily to most conditions, but tend to feel cool. ☐		
Skin	My skin tends to be dry. When very dry it tends to feel rough. ☐	My skin flushes easily and has a reddish or yellowish shade. ☐	My skin is thick, smooth and often feels damp or oily. ☐		

PRACTITIONER USE ONLY:

V PRAKRUTI:	P PRAKRUTI:	K PRAKRUTI:
V VIKRUTI:	P VIKRUTI:	K VIKRUTI:

CATEGORY				√	PRACTITIONER USE ONLY
Skin	When I have rashes, they tend to be dry and itchy. Blemishes are usually blackheads. ☐	When I have rashes, they tend to be red and burning. Blemishes are usually acne. ☐	When I have rashes, they tend to be wet and oozing. Blemishes are usually white pimples. ☐		
Sleep	I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. ☐	I tend to sleep soundly and awaken with ease. ☐	My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. ☐		

MENTAL & EMOTIONAL PATTERNS

Stress	Under stress I often become worried or overwhelmed. ☐	Under stress I often become irritable, but usually rise to the challenge. ☐	Under stress, I often withdraw to observe or become reclusive. ☐		
Decision Making	I am changeable and often have difficulty making decisions. ☐	I make decisions easily, but can change my mind with new information. ☐	I am careful but easy-going about decisions. ☐		
Projects	I like to start projects, but at times have difficulty finishing them. ☐	I like to start and finish projects. Completion is important to me. ☐	I like working on a project, but prefer to let others start them. ☐		

FOR WOMEN ONLY

	Is there a possibility you are pregnant? ☐ ***Yes*** ☐ ***No*** ☐ ***Possible*** Are you menopausal? ☐ ***Yes*** ☐ ***No*** If yes, date of last period _____ *If menopausal, please answer below according to your past menstrual patterns.*		I experience PMS: ☐*often* ☐*sometimes* ☐*not at all*		
	My menstrual cycle is irregular. It comes every _____ to _____ days and lasts _____ days. ☐	My menstrual cycle is regular. It comes every _____ days, and lasts _____ days. ☐	☐*cramps* ☐*bloating* ☐*headache* ☐*weight gain* ☐*irritable* ☐*breast tenderness*		
	My menstrual flow is often light, but may vary. ☐	My menstrual flow is medium heavy, and is usually consistent. ☐	My menstrual flow is heavy and is very consistent. ☐		
	I often have severe, cramping pain during menses. ☐	I sometimes have mild pain during menses. ☐	I rarely have pain during menses. ☐		

PRACTITIONER USE ONLY:

V PRAKRUTI:	P PRAKRUTI:	K PRAKRUTI:
V VIKRUTI:	P VIKRUTI:	K VIKRUTI:

(15) CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, supplements are you currently taking?
Please include significant remedies that you have stopped *taking, including birth control and hormone replacement therapies.*

Substance	Over-the-counter ***(OTC)*** Prescription? ***(Rx)***	Herb/Drug/ Vitamin?	Prescribed by? ***(Self, MD, other)***	For what purpose?	For how long?	What dosage?	What have the benefits been ?

*PATIENT NAME:*_____

Patient Form

Please fill out this form and fax it to us or bring it with you

1. Patient Details

Start Date _____ /_____ /_____ (mm/dd/yyyy) End Date _____ /_____ /_____ mm/dd/yyyy)

First Name _____Last Name_____

Membership Term _____(1 week/1 month/3 months/6 months/12 months)

2. Member Details

Sex _____(male/female) Date of Birth _____/_____ /_____ mm/dd/yyyy)

Company _____

Address _____

_____

_____

City_____ State_____ Zip_____

Telephone (H)_____ (W)_____ (M)_____

E-mail _____

Emergency Contact Name_____

Emergency Contact Phone_____

Have you used a Yoga Studio before? _____(yes/no)

3. Member Declaration & Payment Details

I have read and understood, and agree to the membership terms and conditions of your Yoga Studio as defined on the next page of this membership form, and know that this affects my legal rights. I agree to pay the following fees:

Joining Fee _____ $ Term Fee $_____ Total Fee $_____

Signature _____ Date _____/_____ /_____ mm/dd/yyyy)

4. For Office Use Only

Total Fee Received $_____ Payment Type_____ Staff Initials _____

Date _____/_____ /_____ mm/dd/yyyy) Membership No_____

Introduction Session on _____/_____ /_____ mm/dd/yyyy) Time_____

5. Membership Terms & Conditions

Risks, Injuries & Obligations

I acknowledge that the activity I propose to undertake exposes me to certain risks, and in participating in such an activity:

- I may be injured.
- My personal property could get lost or damaged.
- I may injure other people or damage their property.
- There may not be adequate medical facilities for treatment if I am injured.
- I assume the risk of and responsibility for any injury, death or damage to property resulting from me.

Release & Indemnity

I participate in all activities at your Pulse of Life at my sole risk and responsibility. I release, indemnify and hold harmless *(insert your Yoga Studio's name here*) from and against all actions or claims either made by me or on my behalf by others on account of injury, loss, damage or death caused to me by negligence or otherwise.

Administration

- Proper clothing must be worn at all times.
- Memberships are not refundable or transferable.
- Members must respect other users and behave appropriately with them.

Joining Fee

- A joining fee applies to all new members.
- The joining fee entitles the member to renew membership within an eighteen month period following the expiration of membership.

Term Memberships

Term memberships are for 1 week, 1 month, 3 months, 6 months and 12 months with a start date and an end date.

Suspensions

- Any membership can be suspended by the member for a minimum period of one week and a maximum period of 12 months.
- To suspend a membership, the member must complete a membership suspension form and submit it to us prior to commencement of the suspension period.

Access Cards

All members must bring their access card while visiting our Pulse of Life.