

Ayurvedic Health Consultation

With Shiloh Burrows, Herbalist & Ayurvedic Health Consultant

Please take time to read and complete the following:

- Fill out the enclosed intake form. Please only fill out what you are comfortable with.
- Please note any place you have a question and we will be sure to address it. We will go over this form together during the consultation.
- Please bring in a list of any pharmaceutical or over-the-counter medicines that you take on a regular basis with the frequencies, dosages and dates you take them.
- If you are taking any herbal medicines or supplements regularly, **please bring them in the original container they came in so that I can see exactly what you're taking.** Feel free to bring in as well any other supplements that you have, whether you're taking them or not, so that we can possibly integrate them into your program.
- You are encouraged to bring along any medical records, blood tests, or other pertinent information you think may be helpful.
- Client confidentiality will be observed under all circumstances.

Disclosure Statement: Herbalism and Ayurveda are not licensed by the state of California. My services are complementary in nature. These consultations are for educational purposes only, and do not replace the services of a licensed physician.

Herbal Health Consultation

Thank you for taking the time to fill out this form. Please feel free to put question marks next to any sections that you have questions about, and answer only those you are comfortable answering.

During the consultation we will go over this form together.

This questionnaire asks you to assess how you have been feeling **over the last 4 months**.

This information will help to keep track of how your physical, emotional and mental states change as you adjust your eating habits, lifestyle choices, priorities, supplement program, exercise, stress management, and personal growth.

INTAKE

Name _____ Today's Date _____

Address _____

Phone # Home _____ Cell _____ email _____

Birth Date _____ Gender _____

Occupation _____

Passions/Interests _____

Who do you share your home with _____

What type of practitioners are you currently under the care of?

Would you like any of the above practitioners to be notified of our work together? _____

What would you like help with at this time?

Date of last physical exam _____

Outcome _____

What type of therapies have you tried for your current concern(s)?

Diet Modification Vitamin/Mineral Supplementation Herbal Therapy Homeopathy Chiropractic

Acupuncture Conventional Drugs Other (please specify) _____

Are you still using these therapies? _____

Details of Above (use back if you need more space)

List current health problems for which you are being treated

Major hospitalizations, illnesses, injuries:

Year	Specifics	Outcome

Do you know your current blood pressure? _____ Date last taken? _____

Do you have any allergies? Yes / No If so, what are they? _____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (change in job, work, residence, finances, etc)

Is your job associated with exposure to potentially harmful chemicals or health and/or life threatening activities? Explain

Do you consider yourself Underweight Overweight Just right Your weight today _____

Unintentional weight loss or gain of 10 pounds or more in the last 3 months

Do you have regular bowel movements? Yes / No

How many bowel movements do you have per day? _____ How many per week? _____

Is it ever difficult? _____

How is your digestion? _____

LIFESTYLE

Please circle or fill in the appropriate response.

Your honest answers will greatly help the evaluation process.

Do you...

Exercise adequately? Yes / No How many minutes total per week? _____

What exercise do you do? _____

Sleep well? _____ How many hours per night? _____ Do you nap? Yes / No

Like your work? Yes / No How many hours per week do you work? _____

Are you satisfied with your energy levels? Yes Sometimes No

What would you describe as the two main emotions in your life at this time?

Do you use any of the following on a regular basis (circle)?

Laxatives Coffee Tobacco Marijuana Aspirin Advil/Tylenol/Aleve etc. Alcohol

List any prescription or non-prescription pharmaceuticals that you take on a regular basis, with amounts and how long you have been taking them. Feel free to use the back of the sheet if necessary.

List any herbs or supplements you take now or have taken. Include dates and amounts. **Please remember to bring the bottles with you.** Feel free to use the back of the sheet if necessary.

Are you allergic, or have side effects to, any herbs, supplements, or pharmaceuticals?

What are your favorite foods and herbs/spices?

What foods and herbs do you not like?

MEDICAL HISTORY

- Arthritis
- Alcoholism
- Allergies
- Anger, excessive
- Asthma
- Autoimmune Disease
- Bloating
- Blood Pressure Problems
- Bronchitis
- Bruise easily
- Cancer
- Chronic Fatigue Syndrome
- Carpal Tunnel Syndrome
- Cholesterol, elevated
- Constipation
- Circulatory Problems
- Depression, anxiety
- Diabetes / hypoglycemia
- Diarrhea
- Diverticulitis
- Drug abuse
- Eczema/Psoriasis
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gas
- Gout
- Heartburn
- Heart Disease
- Infection, chronic
- Inflammatory bowel disease
- Insomnia
- Irritable bowel syndrome
- Kidney or bladder disorders
- Liver or gallbladder disorders
- Memory loss
- Migraine headaches
- Nausea
- Night sweats
- Numbness/Tingling
- Sinus problems
- Stroke
- Tendonitis
- Thyroid disorders: High / Low
- Obesity
- Osteoporosis
- Pneumonia

- Skin problems
- Ulcer
- Urinary tract infection
- Varicose veins/hemorrhoids
- Water retention/Edema
- Other _____

- MEN/AMAB
- Prostate enlargement
 - Prostate cancer
 - Prostate pain
 - Burning on ejaculation
 - Impotence
 - Blood in urine
 - Difficulty urinating
 - Dribbling stream of urine
 - Decreased sex drive
 - Infertility
 - Other _____

- WOMEN/AFAB
- Menstrual irregularities
 - Endometriosis
 - Infertility
 - Fibrocystic breasts
 - Fibroids/ovarian cysts
 - PMS
 - Breast cancer
 - Breast Pain
 - Pelvic Inflammatory Disease
 - Vaginal infections
 - Decreased sex drive
 - Pregnant at this time
 - Age of first period _____
 - Date of last Gyn exam _____
 - Mammogram + -
 - Latest PAP Results? _____
 - Form of birth control _____
 - # of pregnancies _____
 - Surgical menopause
 - Menopause
 - 1st day of last menstrual cycle _____
 - Length of cycle _____ days
 - Any recent changes in menstrual flow?
 - Describe _____

- NUTRITION & DIET
- Mixed food (animal/vegetable)
 - Vegetarian
 - Vegan
 - Salt restriction
 - Fat restriction
 - Carb restriction
 - Calorie restriction
 - Specific food restrictions (e.g., dairy, soy, wheat, gluten, eggs)
 - Describe _____
 - Other _____

- FOOD FREQUENCY
- Servings per day:
- Fruit _____
- Dark green or yellow/orange vegetables _____
- Grains, unprocessed _____
- Beans, peas, legumes _____
- Nuts/seeds, raw _____
- Dairy, eggs _____
- Meat, poultry, fish _____
- Candies, cookies _____

- EATING HABITS
- Skip breakfast
 - Two meals/day
 - One meal/day
 - Graze (small, frequent meals)
 - Food rotation
 - Eat constantly, whether hungry or not
 - Eat on the run
 - Add salt to food
 - What foods do you crave? _____

FAMILY HISTORY

Has anyone in your family had any of the following? If so, please specify your relationship to them:

- Cancer
- Diabetes
- Allergies/Asthma
- Alcoholism
- Heart Disease
- High/ Low blood pressure
- Depression
- Arthritis
- Stroke

Client Informed Consent Form

I acknowledge and confirm that:

- I am of legal age and I am requesting a consultation with Shiloh Burrows, Herbalist and Ayurvedic Health Consultant.
- This consultation is not to diagnose or treat disease, but for education and support of wellness.
- I understand that Shiloh Burrows has completed the following education and training: Bachelor of Science in Herbal Sciences; Certification in Ayurvedic Health Consulting; Certification in Massage Therapy, among other certifications.
- I understand that this consultation is not intended to replace medical care and that I will seek medical treatment from a licensed health care provider if required.
- I understand that botanicals and nutritional supplements can interact with medications. For this reason, I have disclosed all medication on the intake form.
- I understand that herbal medicine is not regulated nor approved by the Federal Drug Administration unless otherwise noted.
- I understand that no guarantees are made or implied regarding results from botanical or nutritional supplements or natural health methods, and that achieving wellness requires my commitment to my own good health, whether through diet, exercise, or lifestyle changes.
- I understand that I am under no obligation to follow any of the recommendations for lifestyle changes made by Shiloh Burrows.
- I understand that I am not required to purchase botanical or nutritional supplements through Shiloh Burrows.

In consideration of my acceptance as a participant in this private consultation session, I for my self, my heirs, executors, administrators and assignees do hereby release and discharge Shiloh Burrows, and Align With Light, from all claims of damages, demands, or actions whatsoever in any manner arising from, or growing out of, my participation.

NAME _____

Signature _____ Date _____