PERSONAL REQUEST FOR CONSULTATION AND THERAPY

Dr. Ranvir Pahwa

Confidential information: Please print

Date: m d y

Complete Name_____ Age_____ Sex: M F DOB: M D Y

Address _____City_____ Pro._____ Code_____

Telephone_____ Occupation _____Pt/Ft/Shift Height Weight

Referred by/Found us_____ Marital Status: M S D CL W Physician/Specialist

MAJOR COMPLAINTS SINCE CAUSES

_____

_____

_____

OtherComplaints_____

MEDICATIONS COMPLAINTS ANY ADVERSE EFFECTS

_____

_____

_____

Past Medications_____

VITAMINS, SUPPLEMENTS, HERBS AND HOMEOPATHY

_____

_____

FAMILY MEDICAL HISTORY WHO HAS OR HAD IT

Allergies & List Kinds	Arthritis	Diabetes I or II	High BP	Seizures
	Cancer & kinds			Stroke
		Eczema/Skin Diseases	Low BP	Valve Problems
Arteriosclerosis			Neurological Disorders	
Asthma	Cholesterol	Heart disease/Attack		

YOUR MEDICAL HISTORY

AIDS/HIV	Diabetes	Multiple Sclerosis,	Anxiety/ Depression	Trauma and Injuries
Alcoholism	Dizziness	Mumps	Bipolar	Slip and falls
Allergies (List)	Ear infections/tubes	Pacemaker	Surgeries List Please	(Accidents) Dates
	Eczema	Paralysis		
	Emphysema	Pleurisy		
	Epilepsy	Pneumonia		
	Fevers	Polio		
	Goiter	Psoriasis		
Appendicitis	Gout	Rheumatic fever		
Arteriosclerosis	Headaches/Migraines	Scarlet Fever		
Asthma	Heart burn (acidity)	Seizures		
Birth Trauma	Heart Disease	Sleplessness/Insomnia		
Bronchitis	Heart Valves	Stroke		Varicose veins
Cancer	Hemorrhoids	Viral fevers	Hypothyroid	Venereal Disease
Chicken Pox	Hepatitis	Others (Pl. specify)	Hyperthyroid	Whooping Cough
Cold/Flu	Herpes		Tuberculosis	Others (Pl. specify)
Cold sore (Herpes)	High Blood Pressure		Typhoid fever	
Dandruff	Infections Kinds?		Ulcer	

CARDIOVASCULAR SYSTEM

Low Blood Pressure High	Irregular Heart beat	Artery Blockage	Varicose Veins	Fainting
Blood Pressure	Palpitations, Angina	Chest Pain, Tachycardia	Spider veins	Difficult Breathing
Cholesterol High Low	Angioplasty	Murmurs	Blood Clots	
LDL High Low	By pass		Heart Operation	
HDL High Low				

FOOD AND DRINKS **VEGETARIAN** **NON VEGETRAIAN**

Appetite **High, Low, Medium** **Fast Eater** **Medium** **Slow Eater** **Food Cravings?**	**Glasses or cups of** **Coffee** **Soft drinks** **Teas-** **Black or Green** **Herbal teas- Kinds**	**Artificial Sweetener** **Sugar** **Salty Foods** **Milk cold/hot** **Cheese Kinds** **Yogurt- Sweet, plain** **Fruity**	**Thirst for water** **# Glasses per day** **Juice-What kinds? &** **How much per day?** **Prefer Hot or Cold drinks**	**Alcohol kinds&** **How much?** **Wine** **Whiskey** **Beer** **Rum** **Vodka**
Vegetables/Fruits Kinds	**Grains/Bread Kinds**	**Beans and lentils**	**Meat?** **Chicken** **Beef** **Pork**	**Sea foods?**
Breakfast **Average, Kinds**	**Lunch** **Average, Kinds**	**Dinner** **Average, Kinds**	**Snacks** **Average, Kinds**	**Eating Out** **Times per week**

DIGESTIVE SYSTEM

Indigestion, **Bloating,** **Burping: normal/ excess** **After food without Food** **Acidity/Burning before or after food** **Acid reflex** **Gas formation,** **Flatulence**	**Nausea** **Vomiting** **Bad Breath,** **Intestinal Cramping,** **Itchy Anus,** **Burning Anus** **Rectal Pain,** **Hemorrhoids** **Change in taste:** **Metal, Bitter, Sour other**	**Bowel Movements** **Regular** **Irregular** **Diarrhea/Dysentery** **Constipation**	**Bowel Movements** **Frequency-** **1x, 2x, 3x per day,** **Once in -2days, 3 days,** **Once a week**	**Bowel Movements** **Color** **Texture** **Odor/Smell**

RESPIRATORY SYSTEM

Asthma **Wheezing** **Bronchitis**	**Difficult breathing when lying** **Shortness of Breath**	**Sleep Apnea** **Tight Chest** **Chest pain**	**Smokers cough** **Blood in Cough**	**Cough-wet or dry** **Phlegm: Thin or Thick** **Stringy** **Phlegm Color**

MUSCULOSKELETAL SYSTEM

Muscle pain **Fibromyalgia** **Fibrositis** **Toe pain/Numbness** **Tennis elbow**	**Neck pain** **Shoulder pain** **Frozen Shoulder** **Rib Pain** **Golfers Elbow**	**Arm Pain** **Elbow Pain** **Wrist Pain** **Foot pain** **Thigh pain**	**Hand Pain** **Finger pain** **Finger Numbness** **Calf Pain** **Leg pain**	**Upper Back** **Lower Back** **Knee Pain** **Ankle Pain** **Heel Pain**

LIFE STYLE

Exercise Yes/No **Right after meal** **Empty Stomach** **Morning/Evening**	**Exercise** **Regular** **Irregular** **Gym / Home**	**Exercise** **What Kind?**	**Drugs** **Marijuana and or others pl. mention** **Smoker** **Non Smoker**	**Stress** **Low/medium/high** **Reason**

			Past Smoker	

HEAD, EARS, NOSE, THROAT AND EYES

Head aches **Migraines** **Concussions** **Sore Lips (cold Sores)** **Dry Mouth** **Excessive Salivation**	**Ear Pain** **Hearing Loss** **Tinnitus/Ringing** **Wax, Ear Itch** **Sinusitis** **Sinus Headache** **Polyps** **Post nasal Drip**	**Adenoids** **Tonsils In or Out** **Re-occurring Sore throats,** **Phayringitis** **Laryngitis** **Lumps in throat** **Phlegm** **Swollen glands** **Enlarged Thyroid**	**TMJ** **Facial Pain** **Trigeminal Neuralgia** **Teeth Problems** **Grinding Teeth** **Gums Problems** **Glasses** **Contacts**	**Eye Pain** **Eye Strain** **Red Eyes** **Itchy Eyes** **Spots in Eyes** **Floaters** **Poor Vision** **Blurred Vision** **Night blindness** **Cataract** **Glaucoma**

NEUROPSYCHOLOGICAL

Anxiety y/n reason **Depression y/n reason** **Bipolar** **Schizophrenia**	**Seizers** **Numbness** **Tics** **Tourett's Syndrome** **Autism**	**Memory** **Good fair bad** **Memory Loss** **Lack of Concentration** **Lack of Focus** **Vertigo/Dizziness**	**Abused** **What Kind?** **Irritability**	**Easily Stressed** **Attempted/Considered Suicide** **Consulting Therapist**

GENITO-URINARY AND MALE COMPLAINTS

Urgent urination **Frequent urination** **Pain during urination** **Blood in urine** **Unable to hold urine** **Incomplete urination** **Cystitis** **Dribbling**	**Venereal Disease** **Bed wetting** **Kidney stones** **Urine times per night** **1x, 2x, 3x, 4x___** **Sexually active** **Sexually over active**	**Increased libido** **Decreased libido** **Impotence** **Premature ejaculation** **Nocturnal emission**	**No desire** **Decreased desires** **Always thinking of sex** **Unsatisfied sex** **Others**	**Prostate problems** **Prostatitis** **Prostate enlargement** **Prostate Operation** **Prostate Cancer**

FEMALE SYSTEMS AND PROBLEMS

Menstruation **Age menses began** **Regular irregular** **Length of cycle** **Periods heavy** **Scanty/Missed** **Spotting**	**Cramp** **Pains** **Painful Breast** **Acne worst at Menses** **Breast Lumps**	**PMS** **Yes or NO** **Anxiety** **Irritability** **Mood swings** **Nervous tension**	**PMS** **Appetite increased** **Head aches** **Fatigue** **Dizziness** **Cravings What?**	**PMS** **Depression** **Crying** **Forgetfulness** **Confusion**	**PMS** **Fluid retention** **Weight gain** **Breast tenderness** **Bloating**
Pregnancies y/n **Miscarriages #** **DNC #** **Children #** **Male #** **Female #** **Adopted** **Premature births** **Date of PAP test last**	**Vaginal discharge** **Color:** **clear, white milky, albumin like, yellow** **Clots** **Off smelling** **Yeast Infections y/n** **Treatments**	**Vaginal** **Dryness /itch** **Uterine Fibroids** **Fibroids operated** **Bleeding** **Vaginal sore** **Vaginal odor** **Pelvic inflammatory Dis. (PID)**	**Menopause** **Age at menopause** **Post Menopause** **Menopausal** **Peri-menopause** **Pre-menopause** **Hot flashes** **Head aches** **Fatigue** **Forgetfulness**	**Hysterectomy** **Complete** **Partial** **Hormone Therapy** **What hormones?**	**Endometriosis** **Ovarian cysts** **PCOS** **Tumors** **Breast Cancer** **Warts genital** **Other infections**

SKIN AND MORE

Eczema Parts **Dry** **Wet** **Psoriasis** **Acne** **Acne Rosacea**	**Rashes** **Urticaria** **Hives** **Skin ulcers** **Wounds**	**Fungal infections** **Athletes foot** **Skin Dryness** **Itching**	**Hair loss** **Dandruff** **Alopecia** **Change in the texture of the hairs**	**Graying of Hairs** **Boils** **Acne** **Nails problems**

GENERAL COMPLAINTS

WEIGHT	SLEEP	ENERGY STATUS		
Wants to loose Weight y/n **When did you gained weight?** **How much you want to loose? Wants to Gain weight**	**Sleeplessness** **Insomnia** **Poor sleep** **Interrupted Sleep** **Dream sleep**	**Lack of energy** **Morning** **Afternoon** **Evening** **Fatigued When** **Lack of Strength** **Body feels heavy** **Fatigued in the evening**	**Cold hands and feet** **Poor circulation** **Fevers** **Chills** **Night Sweats** **Sweating Easily** **Muscle Cramps** **Easy bruising or bleeding**	**Body pains migrate** **Leg nervousness** **Effect on pain during Weather Change** **Cold/wind** **rain/humidity** **Snow/ storm** **Morning** **Evening**

OTHER PRACTITIONERS: Have you seen the following? Comment as questioned?

Chiropractor	Massage	Physiotherapist	Naturopath/Homeopath	Nutritionist
Dr. **Reason of visit** **Times visited** **Benefits**	**Therapist** **Reason of visit** **Times visited** **Benefits**	**Therapist** **Reason of visit** **Times visited** **Benefits**	**Dr.** **Reason of visit** **Times visited** **Recommendations & Benefits**	**Name** **Reason of visit** **Times visited** **Recommendations & Benefits**
Acupuncturist	**Herbalist**	**Reiki**	**Yoga/Meditation**	**Others**
Dr. **Reason of visit** **Times visited** **Benefits**	**Name** **Reason of visit** **Times visited** **Recommendations & Benefits**	**Practitioner** **Reason of visit** **Times visited** **Benefits**	**Teacher** **Reason of visit** **Times visited** **Benefits**	**Modality and Practitioner** **Reason of visit** **Times visited** **Benefits**

OTHER RELEVANT INFORMATION:

Please Read and Sign- *If under 18 years old, a parent or guardian must sign

The undersigned, understands that today I am not seeing a medical doctor, but instead an Ayurveda Consultant, Herbalist, Homeopath, Holistic Nutritional Consultant and/or Acupuncturist. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with the Ranvir Pahwa, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future condition(s). I also reserve the right to terminate Ayurvedic, Homeopathic, Herbal, Nutritional and Acupuncture treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in above modalities, that addresses my health in its entirety.

Date **Patient's Signature**

Diet/Nutrition **Constitution** **Supplements** **Dos's/Don'ts** **Exercise**

MODALITIES	SYMPTOMS FEELS WORSE	SYMPTOMS FEELS BETTER
CHANGE OF WEATHER	Air cold and dry Air cold and wet Air cold Air dry Rain Stormy weather winter/summer	Air cold and dry Air cold and wet Air cold Air dry Rain Stormy weather winter/summer
ORGANIC PRODUCTS	Pollen Dust Smoke Cigarette Auto Exhaust Pollution Cat Dogs Other Animals Please Specify	Pollen Dust Smoke Cigarette Auto Exhaust Pollution Cat Dogs Other Animals Please Specify
FOODS	Fatty/oily/greasy Fruits sour or sweet Ice creams Cold foods and drinks Warm foods and drinks Salty foods and snacks Sweet foods and snacks Milk Chocolate Coffee/Black tea After eating/Before eating	Fatty/oily/greasy Fruits sour or sweet Ice creams Cold foods and drinks Warm foods and drinks Salty foods and snacks Sweet foods and snacks Milk Chocolate Coffee/Black tea After eating/Before eating
ENVIRONMENT	Open air Out door cold or warm Indoor Cold or warm Cold water Inside the Bed Warm water Out side the bed Sun	Open air Out door cold or warm Indoor Cold or warm Cold water Inside the Bed Warm water Out side the bed Sun
BODY STATE	Running, Walking, Going upstairs Heights Upon Rest, Little motion, Continued motion, Touch	Running, Walking, Going upstairs Heights Upon Rest, Little motion, Continued motion, Touch
THE TIME OF THE DAY	Evening, Nights, Morning During the day Any particular time	Evening, Nights, Morning During the day Any particular time
SIDEA OF THE BODY	Right Body/extremities/head Left Body/extremities/head	Right Body/extremities/head Left Body/extremities/head
PHOBIAS	**DISLIKES THE FOLLOWING**	**LIKES THE FOLLOWING**
OBJECTS AND PLACES	Snakes, Spider, Insects, birds, other animals e.g. Open space, (Parks, Fields Farm) Crowded, Enclosed space (claustrophobia)	Snakes, Spider, Insects, birds, other animals e.g. Open space, (Parks, Fields Farm) Crowded, Enclosed space (claustrophobia)
OTHERS		