PERSONAL REQUEST FOR CONSULTATION AND THERAPY
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

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OtherComplaints_____

MEDICATIONS COMPLAINTS ANY ADVERSE EFFECTS

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Past Medications_____

VITAMINS, SUPPLEMENTS, HERBS AND HOMEOPATHY

_____

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FAMILY MEDICAL HISTORY WHO HAS OR HAD IT

Allergies & List Kinds	Arthritis Cancer & kinds	Diabetes I or II	High BP	Seizures Stroke
Arteriosclerosis Asthma		Eczema/Skin Diseases	Low BP Neurological Disorders	Valve Problems
	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	Irregular Heart beat	Artery Blockage	Varicose Veins	Fainting
High Blood Pressure	Palpitations, Angina	Chest Pain,	Spider veins	Difficult Breathing
Cholesterol High Low	Angioplasty	Tachycardia	Blood Clots	
LDL High Low	By pass	Murmurs	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** **Past Smoker**	**Stress** **Low/medium/high** **Reason**

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:

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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**