Ayurvedic Health Center

Whatcom county, Washington
360-734-2396
AyurvedicHealthCenter.com

Intake Forms — Please write legibly.

Name:		
Address:		
City, State:		
Telephone—Home:	Cell:	Work:
Email:	Birthdate:	Age:
Birthplace:	Exact Birth time:	
Where did you (mostly) grow up?		
What climate are you most comfortable being in?		
Marital/Partner Status:	# of Children:	Ages:
Occupation:		
Emergency Contact Name & Number:		
Please list why you have chosen to have an Ayurvedic Consultation:		

May we add your email address to our eNewlsetter list? We typically send 1–2 emails per month.	Yes	No

What You Can Expect From Your Ayurvedic Health Care

Ayurveda is a natural healing system that has been successfully practiced for thousands of years. Originating in ancient India, this health and wellness tradition understands that each person's path toward optimal health is unique — because each person is unique. The healing programs we offer are based on effective, time-honored principles that focus on understanding your particular body-mind constitutional type and the unique nature of your imbalance(s).

Each individualized program is formulated for you. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other treatments and therapeutics. The Ayurvedic system is wholly different from the Western allopathic model. In order to successfully incorporate and implement these Ayurvedic principles into your life, regular follow-up visits with your practitioner are recommended.

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

In order to help your practitioner get a sense of where your sensibilities lie, please read through these statements and put a check mark by the ones that resonate with you.

- [ ] Western medicine has nothing / little / a lot to offer me at this time.
- [ ] I am ready to enter into a working relationship with a practitioner — and my body's intelligence.
- [ ] I am ready to commit to improving my health and wellness.
- [ ] I am looking for a guide to lead me through the terrain of improving health and wellness.
- [ ] I am ready to invest in myself.
- [ ] I value a proven modality.
- [ ] I value a relationship with the natural world.
- [ ] I prioritize proactive and preventative self-care.
- [ ] I am ready to change.
- [ ] I take responsibility for myself,
- [ ] I am interested in a holistic approach.
- [ ] I am interested in a creative, out-of-the-box approach.
- [ ] I am interested in a specialized approach.

I have read and understood this information.

Autograph:	Date:

Informed Consent

All who participate in Ayurvedic care through the Ayurvedic Health Center should be advised of the following information:

- The Ayurvedic Health Center is an unincorporated association providing recommendations for improving health and wellness. This is done through consultations, personal practices, Ayurvedic therapies, and education.
- Your Ayurvedic Health Practitioner will work with you on the promotion of optimal health and well-being. Please note that your practitioner will NOT be working with you on specific Western medical diagnosable symptoms or diseases.
- By changing your lifestyle and adding in new practices, you will create the optimum environment for healing to take place. You should notice a greater sense of well-being that will help you to thrive (and not simply survive).
- Your Practitioner is not a Western allopathic medical doctor and may not prescribe or alter your prescription medications.
- Your Practitioner will evaluate all intake information and any findings purely from an Ayurvedic perspective.

Disclaimers

Apologies for the legal-sounding language.

- The Ayurvedic Health Center is not licensed to service federal agents, officers, employees and dependents, agents, nor those of any federal franchises. All such persons are subject to the Bivens decision, and must identify themselves prior to participation in any Ayurvedic Health Center activity.
- You participate in Ayurvedic Health Center offerings at your own risk.
- The Ayurvedic Health Center does not offer medical, financial, or legal advice. No person associated with the Ayurvedic Health Center makes any claims.
- All shared content within the Ayurvedic Health Center is for educational purposes only.

Member Covenant

By engaging with Ayurvedic Health Center, I voluntarily agree to work with Ayurvedic Health Center in a private arrangement.

I will not bring a lawsuit against AHC or any of its members, officers, directors, etc.

I will not contact law enforcement for any event that transpires between members.

All Ayurvedic Health Center activities and transactions are held strictly in full privacy and confidentiality. I will not disclose any Ayurvedic Health Center-related information to any persons or third-parties (ie: health department, medical professionals and centers, insurance companies, social media, the IRS, etc.) for any reason.

I have read and understand the above information.

Autograph:	**Date:**

Financial Policy

1. The Ayurvedic Health Center is an unincorporated association. The Ayurvedic Health Center operates in the private and are explicitly not engaged in commerce. Any use of financial or banking terms is simply for ease of communication.
2. The Ayurvedic Health Center is NOT a medical practice and does NOT diagnose, prescribe, or treat. All content is for educational purposes only.
3. The Ayurvedic Health Center is unable to bill health insurance plans and healthcare spending accounts (HSAs). You may not (and agree not to) directly apply for reimbursements from any third-party entity.
4. The Ayurvedic Health Center is unable to generate a receipt, statement, or superbill for any kind of use.
5. Currently available offerings are available on our website: https://www.AyurvedicHealthCenter.com.
6. We require a ***minimum*** of 24-hours notice for canceling and re-scheduling appointments.
7. We generally conduct consultations in person but may conduct them by phone call or over a video/webinar format.
8. Your individual health protocol often incorporates herbal formulas custom-designed for you by your practitioner. The formula will be made up by an outside apothecary; compensation for the formulas is due directly to them. There may be additional fees for shipping and/or encapsulation of the formula.
9. In lieu of payments and financial transactions, members grant and convey gifts or honorariums, which will be redeemed in lawful money [per 12 USC 411].
10. Gift coupons are valid for six months. Any unused balance after six months is forfeit.
11. Refunds are generally not possible. Some specific exceptions may be made; these will be specific to our agreement.
12. Gifts and honorariums may be made by the following means:
    - cash or fiat currency (FRNs)
    - personal or cashier's check (made out to: Katrina Svoboda Johnson)
    - U.S. Postal Service postal money order
    - .999 silver (bars or coins)
    - .999 gold (bars or coins)
    - Goldbacks or Silverbacks **https://www.goldback.com**
    - Monero cryptocurrency
    - Whole Foods or Haggen gift card(s)
    - Visa gift card(s)
    - Amazon.com gift card(s)
    - Dandelion Organics gift card(s) made out to: Katrina Svoboda Johnson **www.dandelionorganic.com/gift**
    - Azure Standard gift card(s) to: Katrina Svoboda Johnson **www.azurestandard.com/shop/search/azure%20gift%20cards**
    - Liberty Dollar Financial Association ("KatSvo")

I have read and understood these financial policies and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Autograph:	Date:

Confidential History

(1) Health History

Are you under the care of a licensed health care professional or any other healthcare provider? If so, for what reason(s)?	Yes	No
Serious Illnesses:		
Hospitalizations:		
Operations:		
List other pertinent current or past conditions:		
Have you had any cosmetic surgery or procedures performed: If so, please list:	Yes	No
Were your wisdom teeth removed?	Yes	No
I have or have had eczema.	Yes	No
I have or have had psoriasis.	Yes	No

Family History

Indicate which 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	
Notes:		

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 past usage):				

(2) Regular Practices

Exercise / Yoga / Team Sports / Recreation (Specify)	None/Never	Occasional	Several Times per Week
		Daily	Several Times per Month
Long-Distance Travel (include commute if applicable)	None/Never	Occasional	Several Times per Week
		Daily	Several Times per Month
Spiritual Practices / Meditation / Prayer (Specify)	None/Never	Occasional	Several Times per Week
		Daily	Several Times per Month
Creative Activities	None/Never	Occasional	Several Times per Week
		Daily	Several Times per Month

Relationship

a. Please indicate how nourished you feel in your relationship: 1 2 3 4 5 6 7 8 9 10

(1 being the least nourished; 10 being the most nourished)

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

Daily Several Times Per Week Several Times per Month Occasionally Not at all

c. Is your current sexual activity satisfactory? Yes No

Allergies or Sensitivities, including spring and autumnal allergies & hay fever

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

Are there any foods you regularly avoid eating because they give you symptoms? If so, what are the symptoms, and how long after eating do they occur?

Daily Liquid Intake (Include number of 8-ounce cups per day)

Caffeinated Coffee / Tea:	Herbal Tea or Juice:	Plain Water:
Decaff Coffee / Tea:	Soda:	Milk:
Grain / Nut Milk:	Other:	

Habitual Eating Patterns

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

Your Definition of Health

Briefly, what does "Health" mean to you or look like to you?

(3) 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	Notes
Morning:	Awaken			
	Mealtime			
	Activities			
Day:	Mealtime			
	Activities			
Night:	Mealtime			
	Activities			

Sleep Patterns

What time do you regularly go to bed?			What time do you regularly go to sleep?		
Is it easy to fall asleep?	Yes	No	Is it easy to stay asleep?	Yes	No
Is it easy to get up in the morning?	Yes	No	Is it easy to go back to sleep?	Yes	No
Is it easy to sleep in heat?	Yes	No			
Describe any sleep issues you have:					

Energy

Do you need naps?	Yes	No	Does your energy flag? When?	Yes	No
How is your enthusiasm?					
Describe any energy issues you have:					
What is your energy flow / expense during the day?					

Please list any additional information / concerns

(4) Current Medications, Herbs, and/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 or Prescription?	Herb/ Drug/ Vitamin?	Prescribed by? (ie: self, MD)	For what purpose?	For how long?	What dosage?	What have the benefits been?

(5) Mental–Emotional Balance

Please rate your orientation to these common mental–emotional states. You may check boxes in more than one column if that feels accurate to you. Focus on what is true for you over the course of your adulthood —OR— most of the time.

	✔	Sattva	✔	Rajas	✔	Tamas
Diet		largely vegetarian, fresh, organic; few comfort foods		some meat, processed foods, or comfort foods		excess meat, processed foods, or comfort foods
Drinking or Drugs		never		some		frequent
Sleep		little		moderate		lots
Sex Drive		low		medium		high
Control of Senses		good		moderate		weak
Speech		calm, soft		agitated		dull
Cleanliness		high		moderate		low
Work		selfless		personal		lazy
Anger		rare		some		frequent
Desire		little		some		much
Pride		modest		ego		vain
Depression		never		some		frequent
Love		gives		takes		needs
Violent		never		sometimes		frequently
Attached to Money		no		somewhat		very
Contentment		yes		sometimes		never
Forgiveness		easily		with effort		holds grudge
Concentration		good		moderate		poor
Memory		good		moderate		poor
Willpower		strong		variable		weak
Service		frequent		some		rare
Honesty		always		mostly		rare
Peace of Mind		yes		occasional		rare
Spiritual Study		daily		occasional		rare
Meditation		daily		occasional		rare
Expresses Joy		always		sometimes		rarely
		Total Sattva		**Total Rajas**		**Total Tamas**

(6) Indicators of Ama

Please indicate the frequency with which you experience the following symptoms. Focus on what is true for you ***at this time*** in your life.

Symptom	Often	Sometimes	Never
bad breath			
foul-smelling stools, sweat, and/or gas			
lots of wiping after eliminating			
skin break-outs			
strong cravings for fast food or junk food			
a coated tongue			
dull appetite			
digestive upsets			
gray or lusterless skin			
yellow teeth or eyes			
sluggish or irritable elimination			
generalized body pain			
fatigue even though you may have slept well			
feeling sluggish and bloated, especially after a meal			
depression			
susceptibility to infection and disease			
a dull mind or clouded thinking; an inability to focus or to be motivated in life			
Totals			

What are your main stressors?

Please indicate your overall level of stress:	0	1	2	3	4	5	6	7	8	9	10

What are your main sources of support?

(8) Deeper Health Indicators

Exposure to Non-Natural Substances

Practitioner Notes:

I use cleaning products with artificial colors, fragrances, dyes, preservatives, etc.	Yes	No	
I use laundry products with artificial colors, fragrances, dyes, preservatives, etc.	Yes	No	
I use dryer sheets.	Yes	No	
I use body-care products that contain artificial colors, fragrances, dyes, preservatives, etc.	Yes	No	
I use dishwashing products (dish soap, dishwasher detergent, etc.) that contain artificial colors, fragrances, dyes, preservatives, etc.	Yes	No	
I store foodstuffs in plastic containers.	Yes	No	
I eat a lot of packaged and prepared foods.	Yes	No	
I eat "fast food."	Yes	No	
I eat little to no organic foods.	Yes	No	

Gut Microbiome & Liver Toxicity Indicators

Practitioner Notes:

I drink alcohol three times a week or more	Yes	No	
I drink coffee most days.	Yes	No	
I use Round-Up and/or Miracle-Gro products (or similar).	Yes	No	
I take/have taken antibiotics.	Yes	No	
I have had general anesthesia.	Yes	No	
I take/have taken pharmaceuticals.	Yes	No	
I regularly take Tylenol and/or Ibuprofen.	Yes	No	

Heavy Metals Exposure

Practitioner Notes:

I use aluminum cookware.	Yes	No	
I have tattoos (extra points for heavy coverage & for color ink).	Yes	No	
I receive fluoride dental treatments; I take fluoride products; and/or my drinking water is fluoridated.	Yes	No	
My drinking/cooking water comes from a municipal water source.	Yes	No	
I have/had metal in my body (dental implants, amalgam/mercury fillings, artificial joints, broken bone hardware, pacemaker wires, etc.)	Yes	No	
I have received vaccines or shots (ie: childhood, flu, shingles, etc.) (specify)	Yes	No	
I have received one or more Covid injections. If so, list date(s) and brand. What symptoms, if any, did you have afterward?	Yes	No	

EMF Exposure

Practitioner Notes:

Does your home have Wifi?	Yes	No	
Does your work have Wifi?	Yes	No	
How much do you use your cell phone?	Yes	No	
How many hours a week do you sit in front of a computer?	Yes	No	
Do you have an electrical power transformer or cell tower near your home and/or work?	Yes	No	
Do you live 1/4 mile or closer to an electrical substation or high-tension power lines?	Yes	No	
Do you use smart speakers and/or devices?	Yes	No	
Do you watch a lot of TV (how bit is it? how often do you watch it?)	Yes	No	
Do you use a microwave?	Yes	No	
Does your cell phone work in 5G?	Yes	No	

(8) Food Journal

Day 1

Date:							
Time	Food/Beverage Consumed	Amount	Where	With Whom	Preparation Method	Hunger 0–5	Fullness 0–5
Is this a typical day? Yes / No / Explain:							

Food Journal

Day 2

Date:							
Time	Food/Beverage Consumed	Amount	Where	With Whom	Preparation Method	Hunger 0–5	Fullness 0–5
Is this a typical day? Yes / No / Explain:							

Food Journal

Day 3

Date:							
Time	Food/Beverage Consumed	Amount	Where	With Whom	Preparation Method	Hunger 0–5	Fullness 0–5
Is this a typical day? Yes / No / Explain:							