Spirit Path Ayurveda Education

Confidential Client History
to receive Alternative Health Care through
Spirit Path Ayurveda Education
Community- Based Internship Program

Section 1: Client Information

Client's Name:		
Client's Address:		
City, State, Zip:		
Home Phone:	Work:	Cell:
Email:	Date of Birth:	Age:
Marital/partner status:	# of children:	Ages:
Occupation:		
How did you hear about the Spirit Path Internship program?		
Why did you choose to receive an Ayurvedic consultation?		

Section 2: Financial Policy Agreement

1.There is a $ 225 charge for your 4 visit consultation package with an Ayurvedic Health Counselor Intern. Payment is due before or at the initial consultation. This includes the initial interview, report of findings meeting, and two follow-up visits. Additional follow-up visits are $ 80 each.
2.Herbal formulas, if recommended, are at additional cost. Spirit Path does not bill insurance companies for services or herbs.
3. If Panchakarma services are recommended, they may be provided at the Spirit Path Yoga and Ayurveda Wellness Center. Payment for those services is made through the College when the appointments are scheduled.
4. If you miss an appointment with your intern without giving 24 hours notice, a twenty five dollar fee is charged to your account.
5. All payments for services may be made to Spirit Path by check or credit card, or paid to the intern directly.

I have read and understood the financial policies of Spirit Path Ayurveda Education.

Client Signature:	Date:

Section 3: Informed Consent

to receive Alternative Health Care through

Spirit Path Ayurveda Education

Community- Based Internship Program

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

1.The goal of all 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 using the principles of Ayurveda.
2. Spirit Path Ayurveda Education is not a medical college.
3. Our interns are not trained in Western medical diagnosis or treatments.

Intern Name: Heidi Jandel Weiland

is an intern of the Spirit Path Community Based Internship Program.

4. All programs are supervised by Amanda Lyon CAS or another graduate of a recognized Ayurvedic program approved by and under the direction of Amanda Lyon.
5.The supervisors are specialists in Ayurveda, not licensed medical doctors.
6. If you are suffering from a disease or symptom that has not been evaluated by a medical doctor or another licensed health care professional (LHCP), you must be evaluated by a medical doctor. If you choose not to see a medical doctor, you will have to sign an acknowledgment that one was recommended to you.
7. Neither the interns or anyone working at Spirit Path can alter your prescriptions.
8. I give permission for Spirit Path to use the information in my chart for research purposes. (Any publication of our research will not include patient names.)
9. The Ayurveda Health Counselor Intern will focus on treatments designed to prevent illness and promote health with simple herbal formulas, diet, and lifestyle recommendations.
10. If you would like Ayurvedic treatment for symptoms outside of the digestive system or the mind/emotions, we recommend that you schedule an appointment with a Certified Ayurvedic Practitioner or CAP Intern.

I have read and understand the above information.

Client Signature:	Date:

Section 4: Past Medical History:

Include major conditions, dates of treatment, and procedures performed.

1. Serious illnesses:

2. Hospitalizations:

3. Operations:

4. List other pertinent past conditions:

5: Have you been under the care of a licensed health care professional in the past year? (circle) YES / NO

If so, for what reasons:

Is there a possibility that you are pregnant? (circle) YES / NO

Section 5: Family History

Disease	Detail (if applicable)	Relative	Intern Use Only (Notes):
Cancer			
Stroke			
Diabetes			
Heart Disease			
Mental Disorder			
Other (explain)			
Other (explain)			

Section 6: Foods:

What types of foods are eaten on a regular basis?

Breakfast:
Lunch:
Dinner:
Snacks:
Describe any routines you have around eating:
Describe any current or past problems with chronic eating disorders or other food related issues:
List any allergic reactions to any substances:
How many cups of caffeinated beverages do you drink per day?
What types?(i.e.: coffee, tea, soda)
How much water do you drink per day?
How many cups of other non-caffeinated beverages do you drink per day?
What types? (i.e.: coffee, tea, soda, milk, juice)
If you drink alcohol, how many glasses of alcohol do you drink per week?
What types? (i.e.: beer, wine, liqueurs, hard alcohol)

Section 7: Habits and Routines

Describe any regular spiritual practices/meditation:
Describe your exercise routine:
Describe any creative activities:

Section 7: Habits and Routines (cont.)

If you smoke, how many packs of cigarettes do you smoke per day?		
If you smoked in the past, how much did you smoke?		When quit?
Have you had any current or past problems with substance abuse? (circle) YES / NO		
Substance:	Amount:	When quit:
Substance:	Amount:	When quit:
What is the frequency of your sexual activity?		
How many hours of sleep are you getting per night?		
Do you feel well-rested with enough energy to get through your day?		

Section 8: Daily Schedule

Describe your activities from the time you wake up until you go to sleep (eating, exercise, work, etc.)

	Time	Activities	Variations
Awaken			
Breakfast			
Activities			
Lunch			
Activities			
Supper			
Activities			
Bed Time			

Other comments about daily activities:
What would you like to work on changing in your diet, lifestyle, etc?
Intern Use Only:

Section 9: Mind/Emotions

Directions: *Please check symptoms that you experience, how often, the intensity with a '1' being the least, and '10' being the worst. Also check if the symptom has been evaluated by a Licensed Health Care Practitioner (LHCP)*

Intern: *Track symptoms that occur more often than once per month with an intensity of '4' or greater, or concern the patient.*

Concern: 'X'	Symptom	How often?	Describe the intensity: 1 - 10	Evaluated by LHCP?	Intern Use Only	Track Y/N
	Worry					
	Anxiety/Fear					
	Overwhelm					
	Spaciness					
	Self Destructiveness					
	Difficulty remembering					
	Difficulty thinking clearly					
	Anger/Rage					
	Resentment					
	Jealousy/Envy					
	Being Critical					
	Lethargy					
	Sadness					
	Depression					

Section 9a: Additional Emotional Symptoms:

Directions: *Please list any other symptoms you experience emotionally .*

Describe Symptom	How often?	Describe the intensity 1 - 10	Evaluated by LHCP?	Intern Use Only	Track Y/N
1)					
2)					
3)					

Intern Notes:

Section 10: Digestion/Elimination:

Concern: 'X'	Symptom	How often?	Describe the intensity 1 - 10	Evaluated by LHCP?	Intern Use Only	Track Y/N
	Digestive Pain					
	Burning Indigestion					
	Belching					
	Regurgitation					
	Vomiting					
	Excessive Gas					
	Feeling Heavy after Eating					
	Bloating after Eating					
	Hemorrhoids					
	Constipation (<1 BM/day)					
	Loose Stools					
	More than 3 BM/day					
	Diarrhea					
	Constipation & Diarrhea					
	Anal Itching					

Section 10a: Additional Digestive Symptoms:

Directions: *Please list any other symptoms you experience in your digestive system .*

Describe Symptom	How often?	Describe the intensity 1 - 10	Evaluated by LHCP?	Intern Use Only	Track Y/N
1)					
2)					
3)					

Intern Notes:

Section 11: Currently Diagnosed Illnesses

Directions: *Please list any currently diagnosed illness, etc., even if you are experiencing no symptoms.*

Symptom/Diagnosis	Date of Evaluation	Findings	Intern Notes
1)			
2)			
3)			

Please note: *Diagnosed disease conditions are listed here for the intern to understand the overall condition of the patient and to be taken into consideration with the treatment program, not for direct treatment.*

Section 12: Current Medications, Herbs, and Supplements

Please list any medications, herbs, and supplements that you are currently taking as well as any significant remedies that you have recently stopped taking.

Intern: *Please fill out form MED 1 for all medications, herbs, and supplements noted here*

Name of Substance	Prescription, OTC, Herb, Vitamin, etc.	Prescribed by:	Purpose:	Dosage:	What effects have you noticed?