

Ayurvedic lifestyle and nutrition client intake form

Name:	Location:	Date:
-------	-----------	-------

Age:	Sex:	Weight:	Height:
------	------	---------	---------

Vision Statement:

Challenges/symptoms:

Medical diagnosis:

Family medical issues:

How is your social life? Are you happy with it?

Are you currently on any medication? If yes, which ones?

Cleansing

How many bowel movements do you have in a day? Are they formed or unformed?

Do you sweat daily?

How much water do you drink in a day?

Have you ever come across the idea of giving your digestive system a rest?

Do you fast regularly?

Do you practice intermittent fasting?

Nutrition

	Time	What do you usually eat?	Hungry before the meal?	How do you feel afterwards?
Breakfast				
Lunch				
Dinner				
Snacks				

What kind of sugary foods do you have? How often? Home-made or bought?

Movement: describe your ability to do the following, focusing on the range of motion and any discomfort experienced

Touch your toes from a standing position with your legs straight.

While lying on your back, bring one knee to your chest while keeping the other leg straight. Repeat on the opposite side.

Perform a seated spinal twist in both directions. Do you feel any restriction in movement?

Strength: describe your ability to do the following, including the number of repetitions and any restrictions in movement

Push-ups, with or without knees on the floor

Squats

Plank

Physical exercise and yoga

Please describe any breathing exercises you do. How many times a week?

Do you practice Yoga? How many times a week?

What kind of movement is part of your everyday life? For example housework, gardening, shopping, playing with children. If in a sedentary job, do you manage to move about every half an hour?

Do you exercise in the gym, at home or outdoors? What kind of exercise do you do? How many times per week? What is your desired outcome?

Sleep

Do you feel refreshed in the morning?

What time are you in bed? How long does it take you to fall asleep?

Do you find yourself scrolling on your phone before falling asleep?

Do you go to bed physically exhausted?

Do you have a TV in your bedroom?

What time do you switch the lights off?

How many hours of sleep do you need?

Do you wake up in the middle of the night? Sometimes, or regularly? If so, can you fall asleep easily?

Do you find yourself pressing snooze often?

Do you want to get more disciplined with your sleep?

Have you ever read about what traditional healing systems say about the time-window you should be asleep for your body to repair and rejuvenate itself properly?

Do you have insomnia?

What have you tried to improve your sleep?

Peace

Do you have relationships that you can deeply connect with?

Do you have relationships that still need resolving and healing?

How many minutes a day do you listen to or read inspiring thought?

How many minutes do you meditate a day?

What have you tried to have more peace in your life?

Habits and routines

Are you unhappy about any of your habits?

Are there any health-related habits you would like to change?

Are you looking for guidance on anything in particular?