P.O.Box 2244, Nevada City, CA | Intake I | Kim@KimKinjo.com | www.KimKinjo.com | 530-559-0845

Kim Kinjo
AYURVEDA

Patient Intake Form

My promise to you: My mission is to empower you to learn to recognize the patterns of behavior that shape your life. I will teach you the ancient principles of Ayurveda and assess your unique constitution (Prakruti) as well as your current imbalance (Vikruti).

Part of the process will be to provide you with tools and practices that you can integrate at your own pace into your life such as yoga, massage, aromatherapy, dietary changes, herbs, color therapy, meditation and breathing exercises (known as pranayama) that will enable you to make adjustments to your daily routine to promote balance. This process of transformative wellness is not an overnight one, but rather a journey to a more balanced life....not a destination.

My goal is to help you become flexible in the circumstance of life, much like the tree that bends in the wind. Once we bring you into balance, you will not stay there since you are not a static being. Our balance shifts with times of day, circumstances, seasons, age, food intake, exercise, and how we process emotions. The ancient wisdom of Ayurveda provides you with the ability to grow with these shifts instead of being blocked by them. In order to successfully implement these Ayurvedic principles into your life, regular follow-up visits are recommended over a six-month period.

I thank you for allowing me to journey with you on this path of transformation and look forward to growing with you!

Name: _____

Address: _____

City, State, Zip: _____

Telephone – Specify if it's your cell: _____

E-mail: _____ Birthdate: _____ Age: _____

Marital/Partner Status: _____ # of Children: _____ Ages: _____

Occupation: _____ How did you hear of me? _____

Please tell me why you have chosen to have an Ayurvedic Consultation: _____

_____

_____

Emergency Contact Name: _____ Number: _____

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Informed Consent

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

1. Kim Kinjo is not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.

2. Kim will not recommend altering your prescriptions without the approval of your medical doctor. She may suggest that you speak to your doctor about reducing medication when she feels that it is appropriate.

3. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003.

4. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed healthcare professional, Kim will recommend that you receive a proper evaluation and she may provide you with a referral form.

If she refers you to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.

5. I have read and understand the above information and give my permission to begin a program with Ayurvedic Healthcare with Kim Kinjo Ayurveda.

Patient's Signature:_____ Date: _____

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The Ayurvedic Consultation

- Determine your mind-body constitution
- Identify and assess any imbalances that exist
- Provide information and guidance relevant to helping you nourish, stimulate or balance vital energy
- Develop a plan with you for lifestyle changes that improve your general health and wellness

Fees

- Initial Consultation: $_____ (Includes the Report of Findings)
- Each Follow Up Visit: $_____

Important to Note:

- Your customized program often incorporates herbal formulas. These are additional and vary in price depending on the formula and quantity.
- I do not bill insurance companies for services or herbs.
- Appointment cancellations require 24-hour notice. Missed appointments without notice will be charged $25.

Confidentiality

Confidentiality is strictly enforced. At no time will the information contained in your file be disclosed for any reason.

Past Medical History

Include major conditions and dates of treatment and procedures performed.

a. Serious Illnesses: _____

b. Hospitalizations: _____

c. Operations: _____

d. List other pertinent past conditions: _____

_____

e. Have you been under the care of a licensed health care professional in the past year? ☐ Yes ☐ No
If so, for what reasons? _____

_____

f. Have you had any cosmetic surgery or procedures performed? ☐ Yes ☐ No
If so, please list with dates: _____

_____

PATIENT NAME: _____

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Family History

Indicate what 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:
☐ Cancer:	☐ Mental Disorder:
☐ Stroke:	☐ Diabetes:
☐ Other:	☐ Other:

Alcohol, Tobacco and Substance Use

a. Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how often: ☐ Daily ☐ Several times weekly ☐ Several times monthly ☐ Seldom

☐ 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)

_____

_____

PRACTITIONER NOTES

Regular Practices

☐ Exercise / Hatha Yoga (Specify)	☐ None / Never	☐ Occasional ☐ Daily	☐ Several times per month ☐ Several times per week
☐ Team Sports / Recreation (Specify)	☐ None / Never	☐ Occasional ☐ Daily	☐ Several times per month ☐ Several times per week
☐ Travel (Include commute if applicable)	☐ None / Never	☐ Occasional ☐ Daily	☐ Several times per month ☐ Several times per week
☐ Spiritual Practices (Specify)	☐ None / Never	☐ Occasional ☐ Daily	☐ Several times per month ☐ Several times per week
☐ Meditation / Prayer / Pranayama (Specify)	☐ None / Never	☐ Occasional ☐ Daily	☐ Several times per month ☐ Several times per week
☐ Other (Include creative activities)	☐ None / Never	☐ Occasional ☐ Daily	☐ Several times per month ☐ Several times per week

Sexual Activity

According to Ayurveda, a person's level of sexual activity impacts health and well-being in the same way as other aspects of daily life – such as diet or sleep.

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

☐ Daily ☐ Several times a week ☐ Several times a month ☐ Occasionally ☐ Not at all

b. Is your current sexual activity satisfactory? ☐ Yes ☐ No

How nourished do you feel in your relationship? Can also include family and friends (1=least, 10=most) _____

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Food Choices

What types of foods do you eat on a regular basis?

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Daily Schedule

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.
(include approximate times)

Morning	TIME	HABITUAL ACTIVITIES	PRACTITIONER NOTES
Awaken			
Mealtime			
Activities			
Day	TIME	HABITUAL ACTIVITIES	
Mealtime			
Activities			
Activities			
Night	TIME	HABITUAL ACTIVITIES	
Mealtime			
Activities			
Bedtime			

Daily Liquid Intake

(indicate number of 8 ounce cups per day)

☐ Caffeinated Coffee / Tea ☐ Veggie Juice ☐ Cow or Goat Milk ☐ Plain Water

☐ Decaf Coffee / Herbal Tea ☐ Soda or Fruit Juice ☐ Grain / Nut / Soy Milk

Allergies or Sensitivities

Do you have allergic reactions to any substances (including food, pollens, and medicines)? ☐ Yes ☐ No

If yes, please list: _____

_____

Habitual Eating Patterns

Describe any current or past eating patterns or any other food related issues: _____

_____

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Challenging Patterns

Please indicate any physical and emotional patterns that you find challenging by assigning a Frequency (a number from 1 to 3) and Intensity (a number from 1 to 10).

FREQUENCY	INTENSITY
1 = Daily	1 to 3 = Mild Discomfort
2 = Several Times Weekly	4 to 6 = Moderate Discomfort
3 = Several Times Monthly	7 to 10 = Severe Discomfort

DIGESTION	Frequency 1-3	Intensity 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

ELIMINATION	Frequency 1-3	Intensity 1-10
Constipation (less 1 BM / day)		
Alternating constipation & diarrhea		
Food particles in stool		
Rectal pain or hemorrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

EMOTIONS	Frequency 1-3	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-Destructiveness		
Anger		
Resentment		
Critical / Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

Additional Symptoms of Concern	Frequency 1-3	Intensity 1-10

Previously Diagnosed Current Conditions	PRACTITIONER NOTES

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Ayurvedic History

For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to Kim about this please check (✓) in the column to the right.

CATEGORY				✓	PRACTITIONER NOTES
Appetite	☐ If I miss a meal, I often get light-headed, anxious or cranky Practitioner use only ☐ V ☐ P	☐ If I miss a meal, I often get irritable or angry. Practitioner use only ☐ V ☐ P	☐ If I miss a meal, it doesn't really bother me. Practitioner use only ☐ V ☐ P	☐	
Appetite	☐ I prefer to eat frequently with no set schedule, but I often forget to eat. My hunger level is variable. Practitioner use only ☐ V ☐ P	☐ I have a strong appetite, I prefer to eat 3 meals a day at about the same time each day, I rarely skip meals. Practitioner use only ☐ V ☐ P	☐ I prefer to eat 2 to 3 times daily, but can go without eating with no discomfort. Practitioner use only ☐ V ☐ P	☐	
Digestion	☐ After eating, I often experience gas or bloating. Practitioner use only ☐ V ☐ P	☐ After eating, I often experience heartburn or acidity. Practitioner use only ☐ V ☐ P	☐ After eating, I often feel heavy or sleepy. Practitioner use only ☐ V ☐ P	☐	
Elimination	☐ I tend to have irregular bowel movements one time per day or less. Practitioner use only ☐ V ☐ P	☐ I tend to have 1 to 2 bowel movements daily, usually, with regularity and ease. Practitioner use only ☐ V ☐ P	☐ I tend to have one bowel movement per day with no straining or difficu lty. Practitioner use only ☐ V ☐ P	☐	
Elimination	☐ My bowel movements are often dry and hard. At times I may strain to push. Practitioner use only ☐ V ☐ P	☐ My bowel movements are usually well-formed, but sometimes they are loose and may burn. Practitioner use only ☐ V ☐ P	☐ My bowel movements are usually well-formed, slow and easy. Practitioner use only ☐ V ☐ P	☐	
Weight	☐ I usually don't gain weight very easily. Practitioner use only ☐ V ☐ P	☐ When I gain weight, it is fairly easy to lose it. Practitioner use only ☐ V ☐ P	☐ I gain weight easily and lose it slowly. Practitioner use only ☐ V ☐ P	☐	
Body Temperature	☐ My hands and feet often feel cold and I prefer warmer climates. Practitioner use only ☐ V ☐ P	☐ I am warm most of the time no matter what the climate is. Practitioner use only ☐ V ☐ P	☐ I adapt easily to most conditions, but tend to feel cold. Practitioner use only ☐ V ☐ P	☐	
Skin	☐ My skin tends to be dry. When very dry it tends to feel rough. Practitioner use only ☐ V ☐ P	☐ My skin flushes easily and has a reddish or yellowish shade. Practitioner use only ☐ V ☐ P	☐ My skin is thick, smooth and often feels damp or oily. Practitioner use only ☐ V ☐ P	☐	
Personality	☐ When I am balanced I feel creative, enthusiastic, and vivacious. Practitioner use only ☐ V ☐ P	☐ When I am balanced I feel perceptive, disciplined, and logical. Practitioner use only ☐ V ☐ P	☐ When I am balanced I feel nurturing, calm, and devotional. Practitioner use only ☐ V ☐ P	☐	
Sleep	☐ I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. Practitioner use only ☐ V ☐ P	☐ I tend to sleep soundly and awaken with ease. Practitioner use only ☐ V ☐ P	☐ My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. Practitioner use only ☐ V ☐ P	☐	

Below for Practitioner Use Only		
V Prakruit:	P Prakruti:	K Prakruti:
V Vikruti:	P Vikruti:	K Vikruti:

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Catagory	Mental & Emotional Patterns			✓	PRACTITIONER NOTES
Stress	☐ Under stress I often become worried or overwhelmed. Practitioner use only ☐ V ☐ P	☐ Under stress I often become irritable, but usually rise to the challenge. Practitioner use only ☐ V ☐ P	☐ Under stress, I often withdraw to observe or become reclusive. Practitioner use only ☐ V ☐ P	☐	
Decision Making	☐ I am changeable and often have difficulty making decisions. Practitioner use only ☐ V ☐ P	☐ I make decisions easily, but can change my mind with new information. Practitioner use only ☐ V ☐ P	☐ I am careful but easy-going about decisions. Practitioner use only ☐ V ☐ P	☐	
Projects	☐ I like to start projects, but at times have difficulty finishing them. Practitioner use only ☐ V ☐ P	☐ I like to start and finish projects. Completion is important to me. Practitioner use only ☐ V ☐ P	☐ I like working on a project, but prefer to let others start them. Practitioner use only ☐ V ☐ P	☐	

For Women Only			✓	PRACTITIONER NOTES
Are you menopausal? ☐ Yes ☐ No If yes, date of last period: _____	Is there a possibility you are pregnant? ☐ Yes ☐ Possible ☐ No		☐	
If menopausal, please answer below according to your past menstrual patters. My menstrual cycle is: ☐ Irregular ☐ Regular It comes every _____ to _____ days and lasts _____ days. Practitioner use only ☐ V ☐ P	I experience PMS: ☐ Often ☐ Sometimes ☐ Not at all ☐ Cramps ☐ Weight gain ☐ Bloating ☐ Headache ☐ Irritable ☐ Breast Tenderness Practitioner use only ☐ V ☐ P		☐	
☐ My menstrual flow is often light, but may vary Practitioner use only ☐ V ☐ P	☐ My menstrual flow is medium heavy, and is usually consistent. Practitioner use only ☐ V ☐ P	☐ My menstrual flow is heavy and is very consistent. Practitioner use only ☐ V ☐ P	☐	
☐ I often have severe, cramping pain during menses. Practitioner use only ☐ V ☐ P	☐ I sometimes have mild pain during menses. Practitioner use only ☐ V ☐ P	☐ I rarely have pain during menses. Practitioner use only ☐ V ☐ P	☐	

Below for Practitioner Use Only		
V Prakruit:	P Prakruti:	K Prakruti:
V Vikruti:	P Vikruti:	K Vikruti:

PATIENT NAME: _____

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Current Medications, Herbs or Supplements

What medications, herbs, or 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 (OTC) Prescription? (Rx)	Herb / Drug / Vitamin?	Prescribed by? (Self, MD, other)	For what purpose?	For how long?	What dosage?	What have the benefits been?

PATIENT NAME: _____