PATTERNS FOR LIVING

909 Electric Avenue, Suite 302A, Seal Beach, CA 90740
(562) 884-0927

CONFIDENTIAL CLIENT HISTORY

(Please write neatly in INK only)

Appointment Date/Time: _____

Client's Name: _____

Client's Address: _____

City, State, Zip: _____

Telephone—Home: _____ Cell: _____ Work: _____

E-mail: _____ Birth date: _____ Age: _____

Marital/partner status: _____ # of children: _____ Ages: _____

*Is there a possibility that you are pregnant? ❑Yes ❑No Last menstrual Cycle start date: _____

Occupation: _____

How did you hear about Ayurveda and/or Patterns For Living? _____

FINANCIAL POLICY AGREEMENT

1. There is a **$205.00** charge for each initial Ayurvedic consultation with your Clinical Ayurvedic Specialist. This includes the initial interview and report of findings meeting. Payment may be made by cash or check.

2. There is an **$85.00/hour** charge for each Ayurvedic follow-up visit or Lifestyle/Coaching visit.

3. There is a charge for herbal formula design and preparation. The fees for formulas, if any, will be given to you prior to your purchase. All formulations are custom-made and are designed specifically for your constitution and imbalance.

4. Fees for herbs must be paid in advance at the time they are ordered. Payment may be made by cash or check. Patterns For Living does not provide monthly billing.

5. Patterns For Living does not bill insurance companies for services or herbs.

6. If you miss an appointment with your Clinical Ayurvedic Specialist without giving 24 hours notice, a $25.00 fee is charged to your account.

I have read and understood the financial policies of Patterns For Living.

Client's Signature: _____ Date: _____

INFORMED CONSENT

to receive Complementary or Alternative Health Care through

PATTERNS FOR LIVING

All clients who participate in Ayurvedic health care through Patterns For Living should be advised of the following information:

1. *Ayurveda is the traditional healing system of India, which is based on the idea that each person's path toward optimal health is unique. Your program is based on understanding your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other natural therapeutics. 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.*

2. *Patterns For Living is not a Medical Clinic. Devi Mueller is trained in Ayurvedic Medicine through the California College of Ayurveda, a state approved California School. She has completed two years of academic work and an internship under the CCA. She continues to pursue continuing education yearly.*

3. *Devi Mueller is not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.*

4. *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.*

5. *If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If you are referred to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.*

6. *No recommendation will be made for altering your prescriptions without the approval of your medical doctor. Devi may suggest that you speak to your doctor about reducing medication when she feels that it is appropriate.*

9. *While Devi may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, she is evaluating her findings from an Ayurvedic perspective only and not from a Western medical perspective.* ***This examination does not take the place of a medical evaluation.*** *If, as a result of the examination, if any findings are suggestive of a possible medical imbalance, she will refer you to a Medical Doctor for further evaluation.*

10. *I give my permission for Patterns For Living to use the information in my chart for research purposes. (Any publication of our research will not include patient names, addresses, phone numbers, email addresses or social security numbers.)*

I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with Patterns For Living/Devi Mueller.

Client's Signature: _____ *Date:* _____

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? ❑**Yes** ❑**No**
   If so, for what reasons:_____

_____

(Please be sure to include visits for annual physical exams; e.g., gynecological, urological; as well as visits to chiropractors, acupuncturists, etc.)

6. Eating Disorders:

_____

7. Have you had any cosmetic surgery or procedures performed? ❑**Yes** ❑**No**
   If so, please list:

_____

8. Please indicate any difficulties experienced during previous health care visits; e.g., drug reactions and/or allergies, uncomfortable situations that cause you undue pain or suffering (physical or emotional):_____

   _____

9. Please list any questions about your health that you have not felt were addressed sufficiently in the past:_____

   _____

   _____

   _____

   _____

CLIENT NAME:_____

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(2) 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 _____ ❑ Other _____

❑ Cancer _____ ❑ Mental Disorder _____ _____

❑ Stroke _____ ❑ Diabetes _____ _____

(3) 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 long-term past usage):_____ _____ _____	

(4) REGULAR PRACTICES

❑ EXERCISE/HATHA YOGA *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ TEAM SPORTS/RECREATION *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ TRAVEL *(Include commute if applicable)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ SPIRITUAL PRACTICES *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ MEDITATION/PRAYER/PRANAYAMA *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ OTHER *(Include creative activities)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*

(5) 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 (include sex with partner and masturbation):

❑ *Daily* ❑ *Several times per week* ❑ *Several times per month* ❑ *Occasionally* ❑ *Not at all*

b. Is your current sexual activity satisfactory? ❑ *Yes* ❑ *No*

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(6) FOOD CHOICES

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

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

(7) 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			
	Bed-time			

(8) DAILY LIQUID INTAKE *(Indicate number of 8 ounce cups per day)*

❑ Plain water _____

❑ Caffeinated Coffee/Tea _____ ❑ Herbal Tea or Juice_____ ❑ Cow or Goat Milk _____

❑ Decaffeinated Coffee/Tea _____ ❑ Soda or soda pop _____ ❑ Grain/nut/soy milk _____

(9) ALLERGIES OR SENSITIVITIES

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

(10) HABITUAL EATING PATTERNS

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

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(11) 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

A. 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		

B. ELIMINATION

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

C. EMOTIONS

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

(12) ADDITIONAL SYMPTOMS OF CONCERN

	Frequency 1-3	Intensity 1-10

(13) PREVIOUSLY DIAGNOSED CURRENT CONDITIONS

	PRACTITIONER NOTES *Please describe symptoms of diagnosed condition*

*PATIENT NAME:*_____

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CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, supplements are you currently taking?
Please include significant remedies that you have recently stopped taking.
***Please also include birth control and hormone replacement therapy**.*

Substance Name	Over the Counter (OTC) or Prescription (Rx)	Herb/Drug/ Vitamin? Please identify which	Prescribed by? Self or physician	For what purpose?	Taken for how long?	What is your current dosage?	What have been the benefits?