The Center for Vedic Medicine

Client Questionnaire

Name

date

phone

mail address

e mail address

age
birth date
marital status
children
place of birth
time of birth
current place of residence (city and state)
how long at current place of residence
have you lived in other areas of the country or world and where

HEALTH HISTORY

family heath history if known (parents, brothers, sisters, uncles, aunts, grandparents)

personal health history

past hospitalizations

current health concerns

duration of disease

progress of disease

city and country where disease began

does the disease become worse at any particular time of the day or season

complications or side effects of disease

any pains in the body and where

current medications

past medications

current herbal supplements

past herbal supplements

any recreational drug use/frequency/amount (may leave this section blank)

current stress level

frequent coughs or colds

skin rashes

allergies (pollen, dust, animal hair, etc)

do you sunburn easily

how do you feel in hot weather

how do you feel in cold weather

any tremors or twitching

DIET

favorite foods

foods which you dislike

any food allergies

any foods which seem to make you feel worse

how many meals per day

what time are meals taken

typical diet

amount of water per day

how do you feel immediately after eating

any gas or bloating after eating

how do you feel 2 hours after eating

how do you feel 4 hours after eating

do you drink alcohol/type/how much/how often

SLEEP

do you fall asleep easily

what time do you usually go to bed

what time do you usually wake up

how do you feel when you first wake up (tired, rested, etc)

are you a heavy or light sleeper

type of dreams (flying, scary, happy, romantic, etc)

ELIMINATION

frequency of urination

color of urine (dark yellow, light yellow, reddish, white)

any burning sensation during urination

frequency of stools

burning sensation during evacuation

consistency of stools (soft, liquid, hard)

color of stool

shape of stool (banana shape, small soft pieces, hard dry pieces, liquid, etc.)

does the stool float in water

WOMEN ONLY

menstrual cycle

- how often
- do you ever skip a cycle
- typical duration (number of days)
- pain or cramping during period
- pain or cramping before period

typical flow (heavy or light)

LIFESTYLE

favorite hobbies

favorite place to be

favorite sports to watch

favorite sports to play

what do you like to do in your spare time

do you have spare time