

**Welcome** to Fern Life Center. *Please fill out all pages entirely so we may serve your medical needs. This one time inconvenience is essential and appreciated.*

Date: \_\_\_\_\_ Client Name: \_\_\_\_\_ Address: \_\_\_\_\_

Gender(M/F): \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Partner Status (S/M/W/D): \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer phone: \_\_\_\_\_ Spouse Name: \_\_\_\_\_ Spouse birthdate: \_\_\_\_\_

Spouse SS#: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_ Name of insured party: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_ Group#: \_\_\_\_\_

In case of emergency please contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Pager: \_\_\_\_\_

Name of other medical providers and phone/address info: \_\_\_\_\_

**Assignment and Release:** I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Fern Life Center all insurance payments, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions:(signature) \_\_\_\_\_ date: \_\_\_\_\_

### **Rights and Responsibilities**

**Our Promise to you:** Our mission is to empower you, our client to learn to recognize the patterns of behavior that inform your wellness choices. We 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, dietary changes, herbs, meditation and breathing exercises known as pranayama that will enable you to make adjustments to your daily routine to bring yourself back into balance. This process of transformative wellness is not an overnight one, rather a journey to a more balanced life...not a destination. Our goal is to help you become flexible in the circumstances of life, much like the tree that can bend in the wind rather than break. 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. We thank you for allowing us to journey with you on this path to transformation and look forward to growing with you!

**Your Responsibilities:** We ask for a 24-Hour notice of cancellation. Less than 24 hr. notice will require a \$50.00 re-scheduling fee Payment of \$220.00 is due on the day of initial consultation. It is your responsibility to find out if your insurance covers massage if you are going to receive massage therapy. Our Pancha karma therapy is not covered by insurance and half of the total cost is due when the appointment is made and the other half is due at the conclusion of therapy.

Client Signature: \_\_\_\_\_ date: \_\_\_\_\_

Medical Provider: \_\_\_\_\_ date: \_\_\_\_\_



**FAMILY HISTORY**

List illnessness that have occurred in your blood relatives including: **cancer, high blood pressure, heart disease, renal disease, TB, bleeding tendencies, diabetes, stroke, mental disease, drug or alcohol addiction, glaucoma**

Family Member	Current Age	Diagnosis	Age at Diagnosis	Current Health or age at death
Father				
Mother				
Paternal G'Father				
Paternal G'Mother				
Maternal G'father				
Maternal g'mother				
siblings				
siblings				
children				
children				
children				

Immunizations and Reaction: \_\_\_\_\_

Date of last physical exam, pap smear, PSA, lab work: \_\_\_\_\_ Last Dental exam: \_\_\_\_\_

**Environmental history**

**check mark if your work or home environment expose you to the following and describe:**

stress \_\_\_ heavy lifting \_\_\_ hazardous substances \_\_\_ structure built before 1975 \_\_\_ mold \_\_\_ asbestos \_\_\_ loud noise \_\_\_ second hand smoke \_\_\_ radiation \_\_\_ air pollution \_\_\_ motor vehicle emissions \_\_\_ pesticides \_\_\_ sun and UV light \_\_\_ carbon monoxide \_\_\_ chemicals \_\_\_ recent travel outside the U.s. \_\_\_ born outside the u.s. \_\_\_ eaten in fast food restaurant in last 2 weeks \_\_\_ exposed to infectious persons in past 2 weeks \_\_\_

**Health Habits and Daily Routine**

Check which substances you use and describe what kind, how much and how often:

Caffeine \_\_\_\_\_ Soda \_\_\_\_\_ Milk \_\_\_\_\_ Alcohol \_\_\_\_\_

Tobacco (include history and date quit) \_\_\_\_\_ Drugs \_\_\_\_\_

Other beverage types and amounts (juice, water, herbal teas) \_\_\_\_\_

**If you drink alcohol:**

Have you ever felt you should cut down: \_\_\_\_\_ Have people ever annoyed you by nagging you about your drinking? \_\_\_\_\_ Have you ever felt guilty about drinking? \_\_\_ Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? \_\_\_\_\_

**DAILY SCHEDULE** (include approximate times)

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

	Time	Routine	Activity	Variation	Spiritual Practices	Exercise	Foods Eaten
Morning							
Mid-Morning							
Lunch							
Mid-Afternoon							
Evening							
Late Evening							
Night							
Middle of the Night							

Are you sexually active? Y  N  Frequency? \_\_\_\_\_ Have you ever contracted a sexually transmitted illness? \_\_\_\_\_  
 If so, what and when? \_\_\_\_\_ Method of birth control: \_\_\_\_\_

What types of food(s) are eaten on a regular basis?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

Are there any routines around eating?:

Any current or past problems with chronic eating disorders or other food related issues?  Y  N

Do you have allergic reactions to any foods? If yes, please list:

Do you exercise regularly?  Y  N Length of time: \_\_\_\_\_ Times per week: \_\_\_\_\_ Type(s) \_\_\_\_\_

Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite):  
 \_\_\_\_\_

Body temperature: Do you generally run warm or cold? Please explain: \_\_\_\_\_

**Birth History**

Birth: Premature \_\_\_ Breathing problems \_\_\_ Time of birth \_\_\_ Infections \_\_\_ Breech \_\_\_ C-sec. \_\_\_

Childhood: Place lived \_\_\_ Illnesses \_\_\_ Breastfed \_\_\_ Formula \_\_\_ Colic \_\_\_ Milk allergy \_\_\_

**Review of Systems**

Check all symptoms that are of concern to you at this time that you want to discuss with the practitioner. Please indicate any area in which you have experienced a severe episode and indicate if episode was in previous 6 months or prior to 6 months time.

Past	Present	HEAD
		Headaches
		Dizziness
		Fainting spells
		Loss of balance
		Difficulty remembering
		Difficulty thinking clearly
		Thinning or loss of hair

Past	Present	EARS
		Hearing loss
		Ringing
		Earaches–Pain
		Discharges
		Bleeding

Past	Present	EYES
		Pain–soreness in eyes
		Redness
		Burning
		Mucous
		Dryness
		Itching
		Tic/twitch
		Blurred/loss of vision

Past	Present	NOSE
		Loss of smell
		Bleeding
		Pain
		Discharge
		Post-nasal drip
		Sinus Congestion

Past	Present	DIGESTION
		Pain
		Burning indigestion
		Belching
		Regurgitation

Past	Present	MOUTH
		Excessive thirst
		Loss of taste
		Strange taste
		Bad breath
		Lip ulcers or lesions
		Dry/cracking lips
		Tongue pain
		Bleeding gums
		Receding gums
		Tooth pain
		TMJ

Past	Present	NECK
		Pain
		Swollen glands
		Lumps
		Stiffness

Past	Present	CARDIOVASCULAR/PULMONARY
		Pain in chest
		Tightness/pressure in chest
		Heart palpitations/irreg HR
		Painful/difficult or Shortness of breath
		Decreased Endurance
		Persistent cough
		Frequent chest colds

Past	Present	SKIN
		Dry–flakey
		Rashes
		Blisters
		Acne
		Changing or bleeding moles
		Response to insect bites

Past	Present	CIRCULATION
		Varicose veins
		Cold hands–feet
		Swollen ankles
		Calf pain

		Vomiting
		Excessive Gas
		Heavy-Bloaty after eating
		Hemorrhoids
		Constipation (< 1 BM/day)
		Diarrhea
		Both constipation & diarrhea
		Bloody Stool

		Puffy eyes

**FEMALE SYSTEM**

Past	Present	
		Irregular cycle
		Heavy/prolonged bleeding
		Vaginal discharge
		Painful menses
		Missed menses or Spotting
		Discharge
		PMS or Menopausal symptoms
		Pregnancies #
		Miscarriages/abortions #
		Unsatisfactory sex/change in libido
		Genital sores
		Ovarian cyst
		Fibroids
		1 <sup>st</sup> menstrual period date and last menstrual pr. date

Past Present

Past	Present	GENITO-URINARY
		Loss of urinary control
		Painful urination
		Frequent urination
		Urinary retention, dribbling
		Frequent night urination
		Blood in urine
		Pain in kidney/groin area
		Kidney/bladder infections
		Difficulty starting stream

Past Present

Past	Present	BREASTS
		Swelling
		Redness
		Lumps
		Nipple discharge
		Tenderness-pain

Past Present

Past	Present	MUSCLES&JOINTS
		Swelling in joints
		Pain/ache in joints
		Stiff joints
		Persistent muscle/bone pains
		Tremors/tics in muscles
		Muscle weakness/atrophy
		Numbness

**MALE SYSTEM**

Past	Present	
		Prostate gland swollen/painful
		Low sperm count
		Low motility
		Genital sores or lesions
		Genital discharge
		Erectile function difficulty
		Change in libido

Past Present

Past	Present	NERVES
		Loss of taste, smell or touch
		Tingling sensations
		Tremors in limbs
		Uncoordinated muscle/limbs

**Please take a few minutes to go inside of yourself to answer these last questions so that we may better design a program to fit your unique needs. Thank you for your careful consideration. It is very much appreciated.**

1. What are you doing in your life now that brings you peace and harmony?
2. What do you want your spiritual life to look like?
3. What does your spiritual life currently look like?
4. If you could design your perfect state of wellness and balance, what would your life look like?
5. What would you have to give up to achieve this life?
6. How can we best support you to meet your dreams?
7. What does it look like when you are spiraling down emotionally?
8. How do you bring yourself back out?
9. Have you noticed patterns that repeat themselves in your life (only the names, places and occurrences have changed names)?
10. Do you know your purpose in life?
11. Do you have vivid dreams?
12. Please assign a number value to your satisfaction with the following areas of your life; 1 is low and 10 is the highest:  
Physical environment\_\_\_ Career\_\_\_ Fun and Recreation\_\_\_ Health\_\_\_ Money\_\_\_ Romance/Significant other\_\_\_  
Personal Growth\_\_\_ Friends/Family\_\_\_