THREE SEASONS AYURVEDA

A Holistic Medical Practice

Welcome

Thank you for choosing Three Seasons Ayurveda for your holistic health care needs. In preparation for your visit, I am enclosing a Confidential Health History and Intake Packet for you to review, please complete and return to Three Seasons Ayurveda no later than 24 hours prior to your first appointment.

The Consultation Intake Packet includes:

- A Brief Introduction to Ayurveda
- Health Information and History
- Financial Policy Agreement
- Informed Consent
- Directions

Please let me know if you have any questions or concerns and return your forms via mail, scan and email or photo and email:

Three Seasons Ayurveda
1033 3rd St. #309
Santa Monica, California 90403
www.threeseasonsayurveda.com
jeff@tsayurveda.com
310-339-8639

Sincerely,

Jeff Perlman
Clinical Ayurvedic & Panchakarma Specialist. Registered AHG Herbalist. California Massage and Marma Therapist, Iyengar Yoga Instructor, IAYT and Ayuryoga Therapist.

A Brief Introduction to Ayurveda

Ayurveda means “Science of Life”. It is an ancient system of healing that focuses on the complete person, which includes the body, mind and spirit. Western medicine tends to focus on a specific symptom or disease. Ayurveda says that for complete wellness to occur, the body, mind and spirit must be in harmony with each other and it must be naturally resistant to conditions that cause disease.

Ayurveda defines wellness not as “the absence of defined disease” but when all bodily tissues, organs, systems and functions are acting together in a healthy way and are able to maintain health and wellness in spite of potential illness causing influences. Ayurveda believes that by balancing the various mind-body functions the natural intelligence of the body will automatically bring itself to wellness.

Ayurveda uses natural processes and methods whenever possible for bringing wellness and restoring good health. Modern medicine usually attempts to restore health by treating the symptoms of the body or by attacking the disease, and usually uses artificial drugs and medicines to treat these symptoms and diseases. Ayurveda is complimentary to traditional medical practices and does not replace medical diagnosis and treatment.

Ayurveda recognizes that each person has a unique mind-body constitution. Ayurveda then identifies the various components of that individual's constitution, determines where imbalances and disturbances exist, and provides education, guidance and a plan for helping the individual bring about their own improvements in health and wellness.

Ayurvedic practices focus on clearing disturbances and balancing metabolic and energetic patterns that support constitutional resilience. It is the individual’s implementation of the right Ayurvedic practices that brings about balance and wellness. People are more vulnerable to developing pathological illness or disease when vital energies of the mind, body and spirit are disrupted. Ayurveda can assist in learning how to improve health through improved lifestyle habits.

The National Institute of Health Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States. 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. Ayurvedic consultations are considered alternative or complementary to medical practices that are licensed by the State of California.

Three Seasons Ayurveda works with clients through a collaborative planning process. Collaborative planning is a process for developing an understanding between you and Three Seasons Ayurveda for specific services including,

- What Three Seasons Ayurveda can do to help you achieve of your health and wellness objectives.
- What you can do to contribute toward the achievement of your health and wellness objectives.
- How we can cooperate together to facilitate your plan for your health and wellness.

CONFIDENTIAL CLIENT HISTORY

Name: _____

Address: _____

City, State: _____**Zip**: _____

Telephone—Home: _____**Cell**: _____**Work**: _____

E-Mail: _____**Birth Date:** _____**Age**: _____

Partner Status: _____**# Of Children**: _____**Ages**: _____

Occupation: _____

Emergency Contact Name & Number: _____

Referred By:_____

Family Physician:_____

Height: _____**Current Weight**:_____**Goal Weight**:_____

Objectives

Please check the items that reflect your main objectives:

☐ **I want an alternative approach to western medicine for managing illness & disease.**

☐ **I want to improve my lifestyle & dietary practices to improve my health.**

☐ **I want to manage stress, tension & worry to attain a more stable emotional nature.**

Please explain why you are here today and what you hope to accomplish:

Date of last physical examination? _____

Any abnormal blood test results? (cholesterol, thyroid, vitamin deficiency, etc.)

_____

Please tell me your major concerns:

1._____

When did it start:_____ **Diagnosed by:** _____

2. _____

When did it start: _____**Diagnosed by:** _____

3. _____

When did it start: _____**Diagnosed by**: _____

4. _____

When did it start: _____**Diagnosed by**: _____

Are you currently receiving care from any other practitioner or doctor?

Name: _____

For what condition(s)?

_____

Name: _____

For what condition(s)?

_____

Do you have any infectious diseases that you know of? **Yes** ☐ **No** ☐

If yes, please explain: _____

Past serious illnesses, hospitalizations, operations or other conditions with dates:

1._____

2._____

3._____

4._____

Do you have allergic reactions to any substances (medicine, food, environmental, etc.)?

_____

YOUR FAMILY MEDICAL HISTORY

If deceased please list age at time of death & cause

	Age	Health Problems
Father's – Father		
Father's – Mother		
Mother's – Father		
Mother's – Mother		
Father		
Mother		
Sibling		
Sibling		
Sibling		
Sibling		

In what country / countries did your ancestors live in before they came to the US?

_____

What religions / spiritual beliefs were you raised with?

_____

How much do you travel and/or commute on a regular basis?

_____

What are your interests, hobbies, passions?

_____

_____

CURRENT HEALTH CONCERNS

Please indicate any digestive, elimination and psychological patterns that you have by assigning:

Frequency (With a Letter)
C = Constant
D = Several times a day
W = Several times a week
M = Several times a month

Intensity (Number 1 to 10)
1 to 3 = Mild discomfort
4 to 7 = Moderate discomfort
8 to 10 = Severe discomfort

Digestion								
	F	**I**		**F**	**I**		**F**	**I**
Abdominal pain			**Burning indigestion**			**Nausea**		
Excess gas			**Acid reflux**			**Vomiting**		
Belching			**Heartburn**			**Sluggish after eating**		
Bloating			**Ulcers**			**Sleep after eating**		
Food allergies			**Intestinal bleeding**			**Poor appetite**		
Elimination								
	F	**I**		**F**	**I**		**F**	**I**
Constipation			**Diarrhea**			**Mucus in stool**		
Constipation & diarrhea			**Loose stools**			**BM only after meal**		
Rectal pain			**Bloody stool**					
Food particles in stool			**Hemorrhoids**					
Psychology								
	F	**I**		**F**	**I**		**F**	**I**
Worry			**Irritable**			**Lethargy**		
Anxiety			**Anger / rage**			**Sadness**		
Overwhelm			**Intense / sharp**			**Depression**		
Insomnia / fatigue			**Resentment**			**Over-attachment**		
Indecisive			**Jealousy / envy**			**Grief**		
Fear			**Critical of others**			**Procrastination**		
High stress			**Critical of self**			**Poor mental clarity**		

Male Conditions

Difficulty with Erection Yes ☐ No ☐
Problems Emptying Bladder Yes ☐ No ☐
Prostate Enlargement Yes ☐ No ☐
Unusual Discharge Yes ☐ No ☐
Burning Urination Yes ☐ No ☐
Difficulty with Ejaculation Yes ☐ No ☐
Testicle Pain Yes ☐ No ☐
Urinary Force Decrease Yes ☐ No ☐

Female Conditions

Are you pregnant? Yes ☐ No ☐ Possible ☐ How many months? _____

Are you nursing? Yes ☐ No ☐ Age of first menses? _____

Are you taking birth control? Yes ☐ No ☐ Type: _____

Do you keep track of your menses on a calendar? Yes ☐ No ☐

Have you had a hysterectomy? Yes ☐ No ☐

Describe your menstrual patterns, if menopausal, describe patterns when still menstruating:

Regularity: Irregular ☐ Variable ☐ Regular ☐ Length of cycle: _____ # of days (e.g. 3-5)

Quantity of flow: Variable ☐ Light ☐ Moderate ☐ Heavy ☐

Level of discomfort: Mild ☐ Moderate ☐ Painful ☐

Describe any other gynecological problems:_____

_____

Sexual Activity

Are you sexually active? Yes ☐ No ☐

With partner: Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Not at all ☐

Without partner: Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Not at all ☐

Is your current sexual activity satisfactory? Yes ☐ No ☐

GENERAL HEALTH AND LIFESTYLE PATTERNS

Do you exercise regularly? Yes ☐ No ☐

Type: _____Length of time: _____Times per week: _____

Type: _____Length of time: _____Times per week: _____

Type: _____Length of time: _____Times per week: _____

Type: _____Length of time: _____Times per week: _____

How much of the following do you drink per day? (indicate number of 8oz. Cups per day)

☐ **Plain water _____**	☐ **Coffee _____**	☐ **Decaf coffee _____**
☐ **Herbal tea: _____**	☐ **Cow's milk_____**	☐ **Goats' milk _____**
☐ **Soda _____**	☐ **Juice_____**	☐ **Soy milk _____**
☐ **Nut milk_____**	☐ **Other _____**	☐ **Other _____**

Do you drink alcohol? Yes ☐ No ☐ **Preferences:** Beer ☐ Wine ☐ Liquor ☐

If yes, how often: Daily ☐ Several times week ☐ Several time months ☐ Seldom ☐

Do you currently smoke? Yes ☐ No ☐

How many cigarettes per day? _____ **How long have you smoked?** _____

Have you ever smoked? if yes, when did you quit? _____

Any current of past use of any addictions (food, drugs, sex, gambling, etc.)?

Substance: _____ **Amount:** _____ **If quit, when?** _____

Substance: _____ **Amount:** _____ **If quit, when?** _____

Please describe your work life: (1= Least 5= Most)

Level of stress 1 2 3 4 5 **Level of work satisfaction** 1 2 3 4 5

Please describe your primary intimate relationship: (1= least 5= most)

Who _____

Level of stress 1 2 3 4 5 **Level of satisfaction** 1 2 3 4 5

Dietary patterns:

(Please indicate your primary food choices and meal times) ***BE SPECIFIC***

Meal	Time (s)	Typical food and beverages
Breakfast		
Snack		
Lunch		
Snacks		
Dinner		
Late night		

Do you experience emotional eating? Yes ☐ No ☐

Food choices: _____

How many hours of sleep do you get in 24 hours? _____

Do you feel refreshed upon awakening?

Always ☐ Most days ☐ Half the time ☐ Rarely ☐ Never ☐

Daily schedule- *include all activities during you regular day and evening.*

	Time	Activities
Awake		
Activities		
Breakfast		
Activities		
Lunch		
Activities		
Dinner		
Activities		
Bed-time		

Current Medications & Supplements

Substance	Indicate if over the counter, vitamin, herb or MD prescription	Who prescribed: self, doctor or practitioner	Taken for how long?	Current Dosage
	☐ Otc ☐ Prescription ☐ Herb ☐ Supplement			
	☐ Otc ☐ Prescription ☐ Herb ☐ Supplement			
	☐ Otc ☐ Prescription ☐ Herb ☐ Supplement			
	☐ Otc ☐ Prescription ☐ Herb ☐ Supplement			
	☐ Otc ☐ Prescription ☐ Herb ☐ Supplement			
	☐ Otc ☐ Prescription ☐ Herb ☐ Supplement			
	☐ Otc ☐ Prescription ☐ Herb ☐ Supplement			

Your Characteristics and Tendencies

Question	Choose One	√	Question	Choose One	√
My appetite is usually	Variable, I like to eat often		When I start a project I	Like to start have difficult finishing	
	Strong, I prefer to eat 3 x day			Completion is imperative	
	Dull, I forget to eat			Good worker but do not start them	
If I miss a meal, I get	Unsettled, cranky & anxious		When making a decision I am	Changeable, scattered, difficult	
	Irritable, angry & impatient			Easy but, can change mind	
	It does not bother me			Take time & do not feel pressure	
After eating I can feel	Gas & bloating		When stressed I feel	Anxious, worried overwhelmed	
	Heartburn or acidity			Irritable, but rise to the challenge	
	Heaviness & sleepiness			Withdrawal & become reclusive	
My elimination is	Irregular, 0-1 bm per day		My skin is	Dry & rough	
	Regular, 1-2 bm per day			Reddish shade & flush easily	
	Slow/Easy, 1 bm day			Thick, smooth, pale, damp, oily	
My weight history is	I do NOT gain weight easily		When balanced I feel	Creative & enthusiastic	
	I gain weight & I lose it easily			Focused, disciplined & logical	
	I gain and lose weight slowly			Calm, nurturing & devotional	
My body temperature	Hands & feet are often cold, prefer warm climates		My sleep pattern is	Sleep lightly, awaken easily, difficult to go back to sleep	
	Feel warm most of time, no matter what climate I am in			Tend to sleep soundly & awaken with ease	
	Cool most of time, but adapt to most climates			Sleep deeply, it can be difficult to awaken in am	

Financial Policy Agreement
for
THREE SEASONS AYURVEDA

1. The complete Ayurvedic evaluation process consists of two appointments; The Initial Consultation and The Report of Findings are each two hours, and are schedule approximately 5-7 days apart.
2. Follow up appointments are approximately 75 minutes.
3. Payment is due at the time of the first appointment, and follow-up appointments are
4. Travel time for home visits is determined by individual situation.
5. If you miss an appointment without giving 24 hours' notice, the full appointment fee will be charged to your account.
6. There are additional charges for herbal formulations and other services or products. Fees will be explained to you prior to purchase. Additional shipping charges may apply.
7. Payment is by cash, check, Venmo or credit card.
8. Three Seasons Ayurveda does not bill insurance companies for any services.
   I have read and understood the financial policies outlined above.

Clients Signature _____ Date: _____

Informed Consent
To receive a Complementary Health Care through
THREE SEASONS AYURVEDA

1. Ayurveda is the traditional healing system of India and is based on the idea that each person's path towards 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, aromatherapy, massage therapy and other natural therapeutics.
2. Jeff Perlman, the principle of Three Seasons Ayurveda is not a Medical Doctor and is certified by the National Ayurvedic Medical Association, American Herbalist Guild, California Massage Therapy Council, California College of Ayurveda and the International Association of Yoga Therapists.
3. The National Institute of Health Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the US. In the state of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in 2003. Ayurveda is considered alternative or complementary to healing arts that is licensed by the state of California.
4. Three Seasons Ayurveda will not alter any of your current medications without the approval of your Medical Doctor.
5. While we do take blood pressure, vital signs and perform some examination techniques similar to a routine medical examination we are evaluating these findings from an Ayurvedic perspective.

I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with Three Seasons Ayurveda.

Clients Signature _____ Date: _____

Three Seasons Ayurveda

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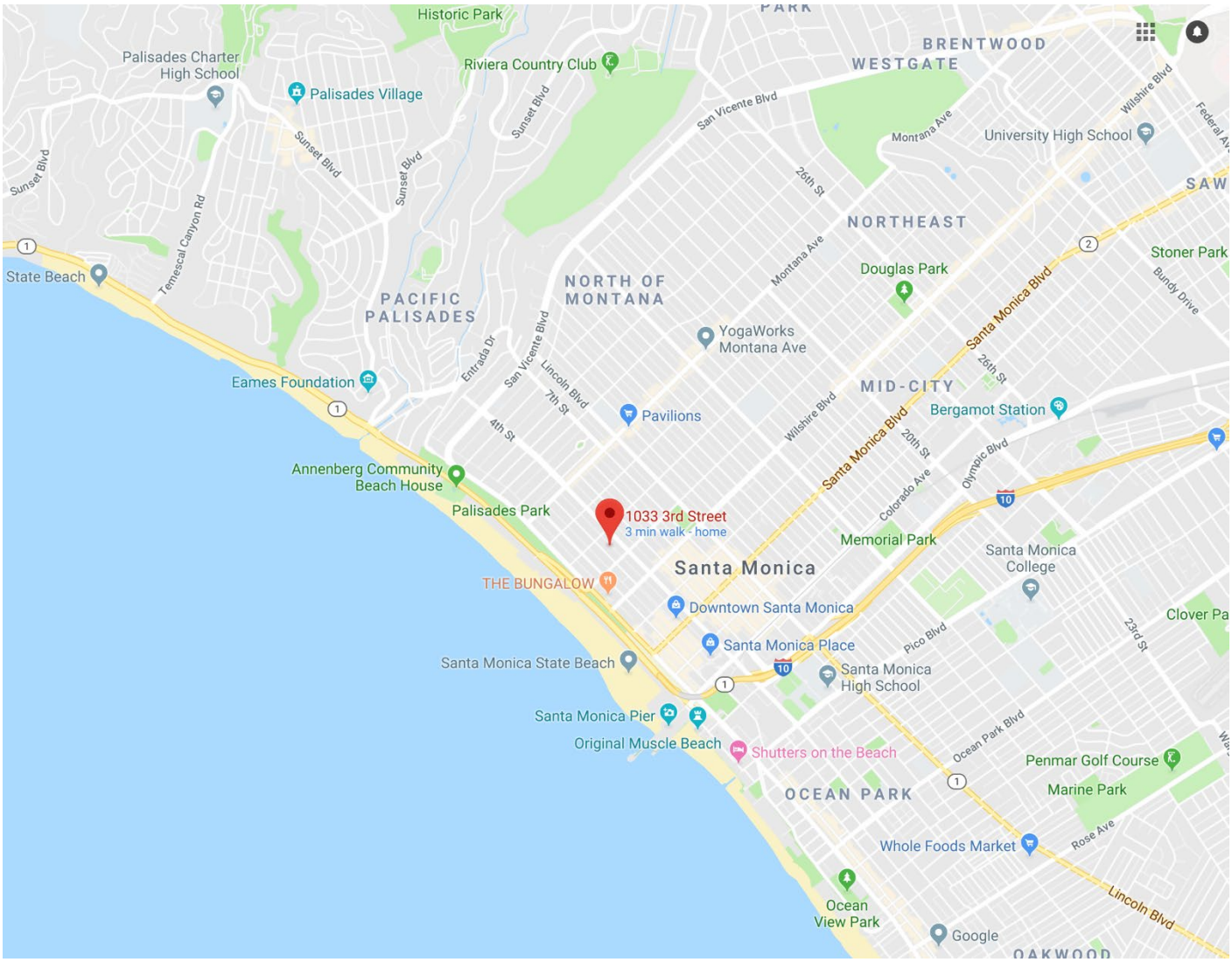

Directions from the East

From Hwy 10 (Santa Monica Fwy) exit 4th street exit and then turn right on 5th street going north.

You will continue past Colorado Blvd, Broadway Blvd, Santa Monica Blvd and turn left on Wilshire Blvd. heading towards the beach.

When you arrive at 3rd street, turn right and go north for two blocks coming to 1033 3rd St.

I have parking for you under the building so please call my cell (310-339-8639) on arrival and I will come down and direct you to the parking space.