Ayurveda Natural Health Center

Midwest's Authentic Ayurvedic Wellness Center

1370 N. Fairfield Rd., Suite E
Beavercreek (Dayton), Ohio 45432
Phone: 937.429.WELL (9355)
Website: www.MidwestAyurveda.com or www.429WELL.com

Client Intake Form

Today's Date: _____

Name: _____ Gender/Pronouns:_____

Address: _____

City/State: _____ Zip code: _____

Daytime phone #: _____ Evening phone #: _____ Cell phone #_____

E-mail Address: _____ Check to receive periodic (usually monthly) e-mail offers: _____

Date of Birth: _____ Place of Birth:_____

Age: _____ Occupation: _____

Marital Status: _____ Name of Spouse/Significant Other: _____

Children's Names and Ages: _____

Whom may we thank for your referral? _____

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Relationship: _____

For any of the questions following, if you need additional space, feel free to attach extra pages. Thank you.

How would you rate the current state of your health? Excellent Good Fair Poor

What are your goals for this session? _____

_____

Are you under medical/therapeutic treatment? ____No ____Yes

If so, please state the type(s) and for what condition(s): _____

_____

List medications and supplements you are currently taking: _____

_____

_____

List any birth control or patches you are currently taking: _____

_____

_____

Specify any known allergies: _____

_____

Please list maternal family history: _____

_____

_____

_____

Please list paternal family history: _____

_____

_____

_____

Please list (approximate date and description) of any accidents, injuries, or surgeries you have had:

_____

_____

_____

_____

Please list any traumatic experiences including neglect, past or current, and approximately at what age of life they happened (as a reminder, all the information on this form is kept confidential).

_____

_____

_____

_____

_____

_____

Indicate stress factors (if any) present in your life: _____

_____

What brings you peace and joy? _____

_____

What places do you enjoy? _____

_____

What activities do you enjoy doing, feel you are successful at doing, and feel empowered by doing them: _____

_____

Describe the types and frequency of exercise activities you engage in: _____

_____

_____

Please describe your daily routine here, include approximate time of day, and what you eat and drink (including snacks), what time you arise and go to bed, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What beverages do you consume and how much? Daily/weekly.

_____

_____

_____

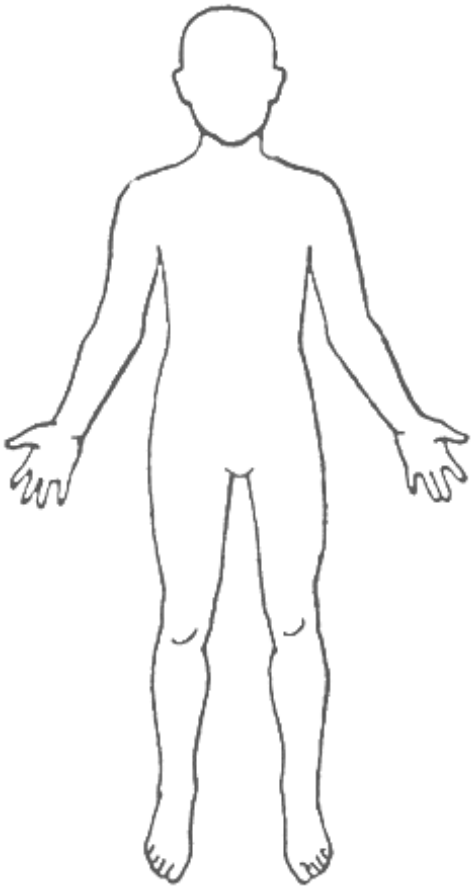
_____

_____

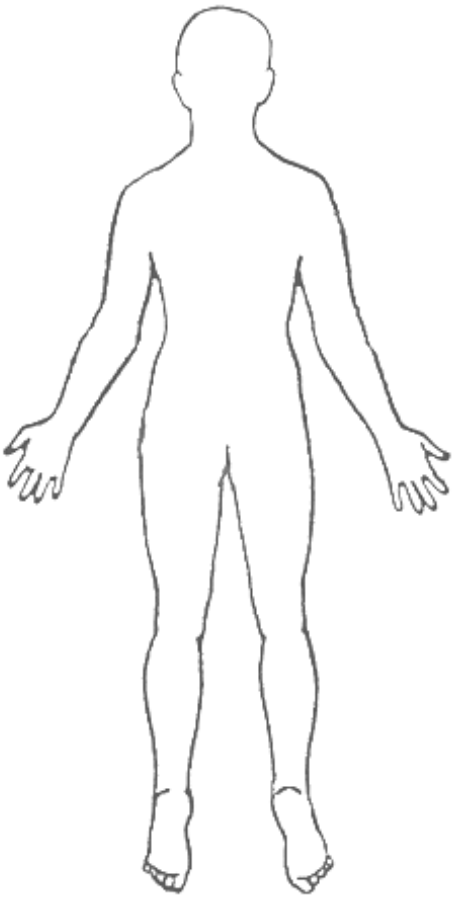
_____

Please mark areas of concern (if any):

Front of body



Back of body



COMMENTS: _____

_____

_____

_____

_____

_____

_____

Health History

Check the following conditions that apply to you, indicating past or present. Please add your comments to clarify the condition.

Musculo-Skeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
o Shoulder, neck, arm, hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendonitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease
o Other: _____

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies
o Sinus problems
o Asthma
o High blood pressure
o Low blood pressure
o Lymph edema
o Other: _____

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery
o Other: _____

Digestive
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Other: _____

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury
o Other:_____

Reproductive System
o Pregnancy:
  o Current
  o Previous – List number___
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Loss of appetite
o Forgetfulness
o Confusion
o Depression
o Difficulty concentrating
o Alcohol use _____
o Nicotine use _____
o Caffeine use _____
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list) _____
o Other congenital or acquired disabilities (please list) _____
o Surgeries _____
o Other:_____

For clients who need mobility assistance, please give your height: _____weight: _____

Please list any additional comments regarding your health and well-being: _____

Consent Form

You need to know that:

1. I am not a medical doctor or nurse
2. I do not diagnose or treat for a specific illness
3. I do not prescribe or adjust medication
4. Sessions at the Ayurveda Natural Health Center are not substitutions for medical treatment but are complements to most types of therapy.

I understand the following: (Please initial next to each paragraph)

_____ I understand that the care I receive is provided for the purpose of relaxation and tension relief. If I experience discomfort or concerns during my session, I will immediately inform the practitioner so that the pressure can be adjusted to my comfort level, my position can be adjusted on the massage table or in the chair, or certain essential oil aromas can be removed from the area.

_____ I understand that nothing said, done, performed, or printed by the practitioner is intended to take the place of a licensed physician. I further understand that this session should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or medical specialist for any mental or physical ailment that I am aware of. I accept total responsibility for my own health care maintenance. This work is not a medical treatment; it is a form of health maintenance.

_____ I understand that there may be some physiological responses that are sometimes related to the self-healing process, such as: nausea, dizziness, diarrhea or muscle soreness, all of which may occur naturally as part of a cleansing process due to the above treatments.

_____ Because some modalities should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

_____ I understand that all services are meant for education, relaxation and to help improve wellness. Any inappropriate behavior with our practitioners will not be tolerated at any time. The session will be terminated immediately, without refund, and the offender will not be allowed back.

CANCELLATION POLICY

To provide affordable quality care to our clients, and minimize delays in getting timely appointments, our office has the following policy regarding canceling, missing or rescheduling appointments:

Cancellations or rescheduling of appointments must be done at least 2 business days (M-F) before your scheduled appointment **BY EMAIL** to info@midwestayurveda.com (or phone, only if email is not possible), or you will be charged the full appointment cost. All missed appointments will be billed for the full appointment cost, and patients will not be allowed to reschedule until the bill has been paid in full.

Thank you for your cooperation of our valuable time and yours.

I have read the above policy and stated all health conditions of which I am aware. This information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____

COVID 19 Procedure & Consent Form

To proceed with receiving care, I confirm and understand the following:

I understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. To the best of her ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you to proceed with providing care.

If I should exhibit any of the symptoms within the next 14 days of an in-person visit, I will notify my treatment provider immediately.

I understand that this practitioner offers alternatives to in-person care, such as remote sessions that include pulse assessment and bodywork, among other treatments. **I understand that should I experience any of symptoms of fever, dry cough, sore throat, shortness of breath, runny nose, and loss of taste or smell, I can schedule or change my appointment to a remote session.**

_____ I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ OR HAVE HAD READ TO ME THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM THE PROVIDER IN THIS PRACTICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

Parent/Guardian Signature (in case of minor): _____ Date: _____

NOTICE OF PRIVACY PRACTICES

We understand the importance of and are committed to keeping your personal, health, and payment information private.

Your Personal and Health Information

This health center collects personal and health information about you and stores it in a file, which is locked at all times when not in use by the care team. This is your health record. The health record is the property of this natural health center, but the information in the health record belongs to you. At the end of each appointment, we provide you with a copy of the summary notes that goes into your file.

The law permits us to use or share your personal or health information for the following reasons:

- Treatment. We use personal and health information about you to provide your care. We may share this information with others who are involved in providing the care you need. For example, we may share your health information with our massage therapists or others who provide complementary services. We may also share health information with your family or others who help you if you have given us permission to do so.
- Appointment Reminders. We may use your personal information to remind you about appointments. If you are not home, we may leave this information in your voicemail.
- Required by Law. We will share your health information when the law requires us to do so. This may include (but is not limited to) reporting abuse, neglect or domestic violence; or responding to judicial, administrative, workers' compensation or law enforcement requests; or complying with audits, investigations, inspections, licensure, or other procedures.

We will never sell your personal health information.

Your Payment Information

This health center does not accept health insurance; therefore, payment information may be collected depending on how payment is secured. We do not save any payment information without your consent. When payment information is saved, it is collected and stored in secured payment software programs (such as PayPal, Stripe, Clover, etc.) with robust protections and privacy policies.

Before we use stored payment information to process a charge, we will always ask for consent and verify the payment credentials to the best of our ability.

We do not share your payment information with anyone.