Ulli
AYURVEDA

Welcome!
Thank you for considering me for your holistic and natural health care needs. In preparation for your consultation, find enclosed a Client Health Profile for you to review, complete and bring with you to your first appointment.

Ulli Ayurveda is a synergistic integration of the one of the oldest, continuously practiced traditions of medicine on the planet—Ayurveda—and modern nutritional and herbal medicine. Ayurveda respects that the human body, mind, spirit and soul are an inseparable whole, and essentially comprised of energy and consciousness. It also believes that humans are both deeply connected to and inter-dependent with nature. Disease is understood in terms of disharmony among the different levels of our existence (body, mind, spirit and soul), or between ourselves and nature.

Respecting the truly holistic nature of our being, I utilize several integrated approaches not only to address specific health issues but also to achieve optimal metabolism and weight, strong immunity, balanced energy, and a clear, calm and positive state of mind:

- Through **Ayurvedic Lifestyle & Diet Consultations**, I will guide you in developing daily routines and eating habits best suited to your metabolic type and the daily and seasonal biorhythms.

- Through **Holistic Herbal Consultations**, I will develop personalized herbal strategies and formulas that will meet the specific needs of your body and mind, using only the highest-quality organic and/or wild-crafted herbs.

- Through educating you in **AyurPrana, AyurYoga, Holistic Nutrition, and Eastern Philosophies**, I will empower you to take better control of your health and achieve personal fulfillment.

To your radiant health and wellbeing.
Yours,

Ulli Allmendinger
MSc Ayurveda

ULLI AYURVEDA CLIENT HEALTH PROFILE

All the information you give will be kept confidential.

Name_____Date_____

Home Address_____

City, Area, Neighborhood_____ Post Code _____

Home Phone _____GSM: _____

Email _____ Would you like to join our mailing list? _____

Date of Birth _____ Time of Birth _____ Place of Birth _____

Age _____ Occupation _____ Marital Status _____

Children & Ages _____

Main Physician _____ Phone _____

1. What are your main health concerns and when did they begin?_____

2. What would you like to achieve in terms of your health and wellness? _____

3. Are you currently receiving care from any other natural health professionals? Please provide names.

4. Are you taking any medications and/or supplements (vitamins, herbs)?

NAME	PURPOSE	DOSE	FREQUENCY

5. Do you use any of the following?

   Cigarettes? _____Years _____Amount _____

   Have you smoked in the past? _____When did you quit? _____

   Recreational drugs? _____What types? _____How frequently?_____

   Alcohol?_____What types?_____How frequently? _____

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Coffee? _____How many cups per day_____Black tea?_____How many cups per day? _____

6. Health History: Have you or a family member been diagnosed with any of the following conditions (check boxes that apply and write when the diagnoses was made):

CONDITION	MYSELF	FAMILY MEMBER PATERNAL	FAMILY MEMBER MATERNAL
Allergies	❒	❒	❒
Anemia	❒	❒	❒
Asthma	❒	❒	❒
Emphysema	❒	❒	❒
Chronic Obstructive Pulmonary Disease (COPD)	❒	❒	❒
Tuberculosis (TB)	❒	❒	❒
Hypertension	❒	❒	❒
High Cholesterol	❒	❒	❒
Heart Disease	❒	❒	❒
Hepatitis A	❒	❒	❒
Hepatitis B	❒	❒	❒
Hepatitis C	❒	❒	❒
Diabetes	❒	❒	❒
Thyroid Disease	❒	❒	❒
Mononucleosis	❒	❒	❒
Any Venereal Diseases (STDs)	❒	❒	❒
Kidney Disease	❒	❒	❒
Osteo-Arthritis	❒	❒	❒
Rheumatoid Arthritis	❒	❒	❒
Cancer	❒	❒	❒
Multiple Sclerosis	❒	❒	❒
HIV / AIDS	❒	❒	❒
Psychiatric Disorders	❒	❒	❒
Eating Disorder (Anorexia or Bolemia)	❒	❒	❒
Stomach Ulcers	❒	❒	❒
Crohn's Disease	❒	❒	❒
Ulcerative Colitis	❒	❒	❒
Celiac Disease	❒	❒	❒
Irritable Bowel Syndrome	❒	❒	❒

Please list any other major diseases that you or a family member have been diagnosed with in the past:

7. List major accidents, injuries, surgeries and/or other hospitalizations and their dates?

ULLI AYURVEDA CLIENT HEALTH PROFILE

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8. Health Profile (Please check anything apply to you and fill in related information)

GENERAL

Height _____Weight _____What is your desired weight?_____

Significant weight changes in the past _____

Do you exercise regularly? _____How frequently? _____

Types? _____

How would you describe your overall energy level? ❒ Very good ❒ Good ❒ Low ❒ Very low
When in the day is your energy usually highest? _____
When in the day is your energy usually lowest? _____

Body temperature: ❒ I usually feel cold ❒ I usually feel hot ❒ Usually only my hands / feet feel cold / hot
❒ Usually comfortable; neither too hot or too cold ❒ I prefer warm/hot weather ❒ I prefer cool/cold weather

Other: _____

Sweating: ❒ I sweat easily & profusely ❒ I sweat very little or none ❒ I sweat at nights ❒ I sweat normally

Other: _____

Food & drink: Do you feel like you have a healthy diet? ❒ Yes ❒ No ❒ I am not sure
Do you feel like you drink enough water? ❒ Yes ❒ No ❒ I am not sure

Other: _____

EYES

❒ Far-sighted ❒ Near-sighted ❒ Astigmatism ❒ Blurred vision ❒ Poor night vision ❒ Floaters
❒ Cataracts ❒ Glaucoma ❒ Pain/ soreness ❒ Itching ❒ Tearing ❒ Broken vessels

Other_____

EARS, NOSE, THROAT (MAJJA & ASTHI DHATU, PRANAVAHA SROTAS)

❒ Frequent Earaches ❒ Poor hearing ❒ Tinnitus
❒ Nasal Congestion ❒ Sinus Congestion ❒ Nasal dryness ❒ Nasal drainage ❒ Nosebleeds

Other_____

TEETH

❒ Cavities ❒ Root Canal ❒ Implants ❒ Gum infection ❒ Grinding teeth ❒ Clicking jaw ❒ Jaw pain

Other_____

NEURO-PSYCHOLOGICAL (MAJJA DHATU, MANOVAHA SROTAS)

❒ Poor sleep ❒ Poor memory ❒ Difficulty concentrating ❒ Depression ❒ Irritability ❒ Anxiety
❒ High stress levels ❒ Foggy or spacey feeling ❒ Dizziness ❒ Migraine ❒ Headaches ❒ Loss of balance
❒ Lack of coordination ❒ Muscle spasm/twitching ❒ Seizures ❒ Numbness, if yes, where? _____

Other_____

RESPIRATORY (PRANAVAHA SROTAS)

❒ Hayfever ❒ Bronchitis ❒ Asthma ❒ Pneumonia ❒ Pain on breathing ❒ Shortness of breath ❒ Cough
❒ Difficulty breathing when lying down ❒ Mucous in throat ❒ Production of phlegm, what color? _____

Other_____

IMMUNOLOGICAL (RASA DHATU)

❒ Frequent colds, how often? _____times / year
❒ Sore throat, how often? _____times/ month
❒ Canker sores, how often? _____times/ year
❒ Cold sores, how often? _____times/ year ❒ Swollen glands

Other_____

CARDIOVASCULAR (PRANAVAHA SROTAS, RASA/RAKTA DHATU)

❒ High BP ❒ Low BP ❒ High cholesterol ❒ Irregular heart beat ❒ Palpitations ❒ Chest pain or pressure ❒ Fainting ❒ Breathing difficulties ❒ Cold hands / feet ❒ Ankle swelling ❒ Easy bruising ❒ Varicose veins

Other_____

APPETITE & DIGESTION (ANNAVAHA & PURISHAVAHA SROTAS)

❒ Very strong appetite ❒ Poor appetite ❒ Food cravings -What kind? _____❒ Bad breath ❒ Indigestion ❒ Abdominal pain ❒ Heartburn / Reflux ❒ Gas ❒ Bloating ❒ Nausea ❒ Vomiting ❒ Pain / discomfort below ribs ❒ Difficulty digesting fatty meals ❒ Gallstones – When?_____

Other_____

ELIMINATION

❒ Diarrhea ❒ Loose stools ❒ Constipation ❒ Blood in stools ❒ Mucous in stools ❒ Black stools ❒ Rectal pain ❒ Hemorrhoids

How frequently do you usually have a bowel movement? ❒ More than 2 times per day ❒ 2 times per day ❒ Once per day ❒ Once every 2 days ❒ Once every 3 days ❒ Less than every 3 days

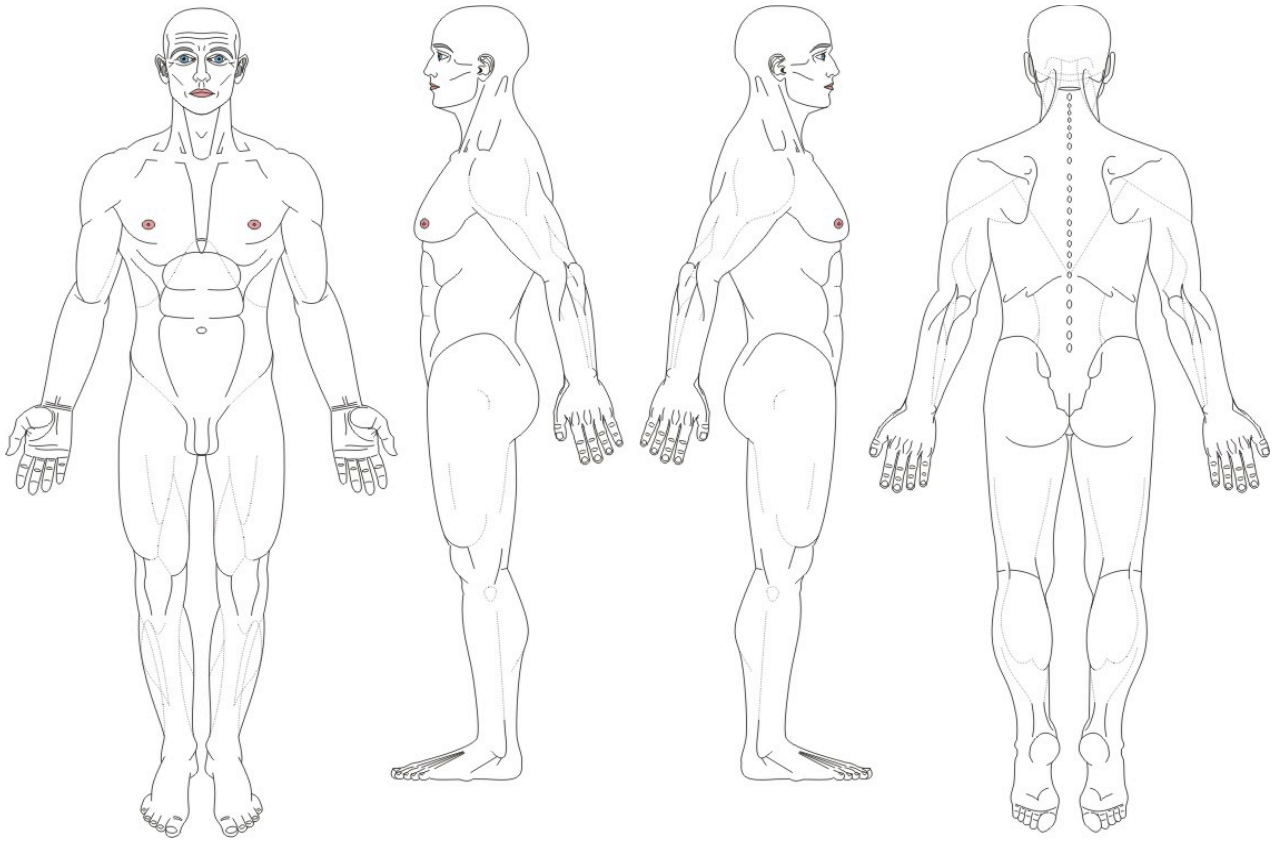
Other_____

MUSCOSKELETAL (MAMSA, ASTHI DHATUS)

❒ Neck pain ❒ Back pain ❒ Hip pain ❒ Knee pain ❒ Shoulder pain ❒ Pain of arms / legs ❒ Pain of hands / feet ❒ Muscle pain ❒ Muscle Stiffness ❒ Muscle weakness ❒ Reduced range of movement ❒ Cracking, popping joints ❒ Joint pain / stiffness ❒ Broken bones ❒ Osteopenia

Other_____

In the diagrams below, please shade all areas where you currently or regularly feel discomfort:



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SKIN, HAIR, NAILS (RASA, RAKTA, ASTHI DHATU)

❒ Dry Skin ❒ Oily Skin ❒ Pimples ❒ Pustules ❒ Itching ❒ Rashes ❒ Hives ❒ Eczema ❒ Psoriasis
❒ Recent moles ❒ Liver spots ❒ Poor healing sores ❒ Easily bleeding ❒ Poorly healing wounds
❒ Dry hair ❒Oily hair ❒ Thinning / weak hair ❒ Dandruff ❒ Hair loss ❒ Scalp itching
❒ Brittle nails ❒ Ridges on nails ❒ White spots on nails ❒ Clubbing of nails

Other_____

URINARY (MUTRAVAHA SROTAS, SHUKRA DHATU)

❒ Painful or burning urination ❒ Frequent urination ❒ Urgency of urination ❒ Dribbling at the end of urination
❒ Urinary incontinance ❒ Blood in urine ❒ Cloudy urine ❒ Frequent Urinary Tract Infections
❒ Kidney / bladder stones ❒ Water retention / Edema; if yes, where? _____

Other_____

MALE-REPRODUCTIVE

❒ Prostate enlargement ❒ Testicular pain, discomfort, swelling ❒ Other inguinal pain or discomfort
❒ Erectile dysfunction ❒ Premature ejaculation ❒ Low libido

Other_____

FEMALE-REPRODUCTIVE

❒ Vaginal discharge, if yes what is the color and consistency? _____ ❒ Vaginal itching
❒ Ovarian cysts ❒ Uterine fibroids ❒ Fibrocystic breasts ❒ Anemia ❒ Pain with intercourse

Do you menstruate? _____What age did you have your first period (menarche)? _____

Length of your cycle (period to period)? _____Duration of bleeding?_____

Light, normal, or heavy? _____

Do you have premenstrual symptoms (PMS)? Check if applicable:
❒ Anxiety ❒ Mood Swings ❒ Depression ❒ Craving Sweets ❒ Dizziness ❒ Headaches ❒ Insomnia
❒ Increased Appetite ❒ Decreased Appetite ❒ Abdominal Bloating ❒ Diarrhea ❒ Constipation
❒ Fatigue ❒ Breast Tenderness ❒ Water Retention ❒ Lower Back Pain

How many pregnancies have you had? _____Births? _____Miscarriages? _____Abortions? _____

Do you use contraceptives? _____If so, which ones? _____

Are you post-menopausal? _____If yes, when was the approximate date of your last period? _____

If you have menopausal symptoms, please describe your major symptoms. _____

_____

Other gynecological issues? _____

_____

Thank You For Taking The Time

Legal Disclaimer:

Services offered at ***Ulli Ayurveda*** are not intended to diagnose or treat any disease, nor are they an alternative to the treatment prescribed by your doctor. If you have a medical diagnosis or you suspect you may have a serious medical condition, you should see a specialist for the appropriate medical intervention. The nutritional, lifestyle and herbal consultations offered at my center are intended for providing information and recommendation only. They are not a prescription, or otherwise obligatory.

I, the undersigned, hereby confirm that I have read, understood and agreed to the above statement, and that I am consulting with practitioners at ***Ulli Ayurveda*** of my own free will.

Signature _____Date _____

Print name _____