VANASHREE AYURVEDA LLC

Health questionnaire

Name- **Age-**
Date of birth- **Profession-**
Phone- **Email-**

Please fill out this form prior to your appointment and email the scanned copy.

1) Please mention your present symptoms/health issues with appropriate duration.

2) Medical history-
• Surgeries-

• Hospitalizations-

• Long standing Medical illness-

• Pregnancies-

3) Do you take any Vitamins/supplements?If yes, please mention the name and the dosage.

4)Emotional/mental health-
Please list any significant emotional trauma from your past or any emotional challenges you are facing in your life currently.

5)Meals-
• How many meals do you have in a day?

• Do you have meals on a routine? YES/NO

• What snacks do you have regularly?

• Do you have any cravings? Please list them-

• Please circle the appropriate option-
Do you drink any of the following everyday?Please mention the type and amount under the selected option.

Coffee/tea/Alcohol

6) Do you smoke? or Do you have a history of smoking? YES/NO
If yes, then please specify the amount.

7) Why did you choose Ayurveda? What do you expect from this consult?

8) Other concerns-

Thank you for completing the questionnaire.