Three Seasons Ayurveda

A Holistic Health Practice

Established 2010

Thank you for considering Three Seasons Ayurveda for your holistic healthcare needs. In preparation for your consultation, please review all information, complete forms, and return to Three Seasons Ayurveda no later than 48 hours before your first appointment to help me prepare for your visit.

I look forward to working with you on your health concerns and holistic health path, and please let me know if you have any questions.

Three Seasons Ayurveda
Jeff Perlman
www.threeseasonsayurveda.com
jeff@tsayurveda.com – 310-339-8639

Location

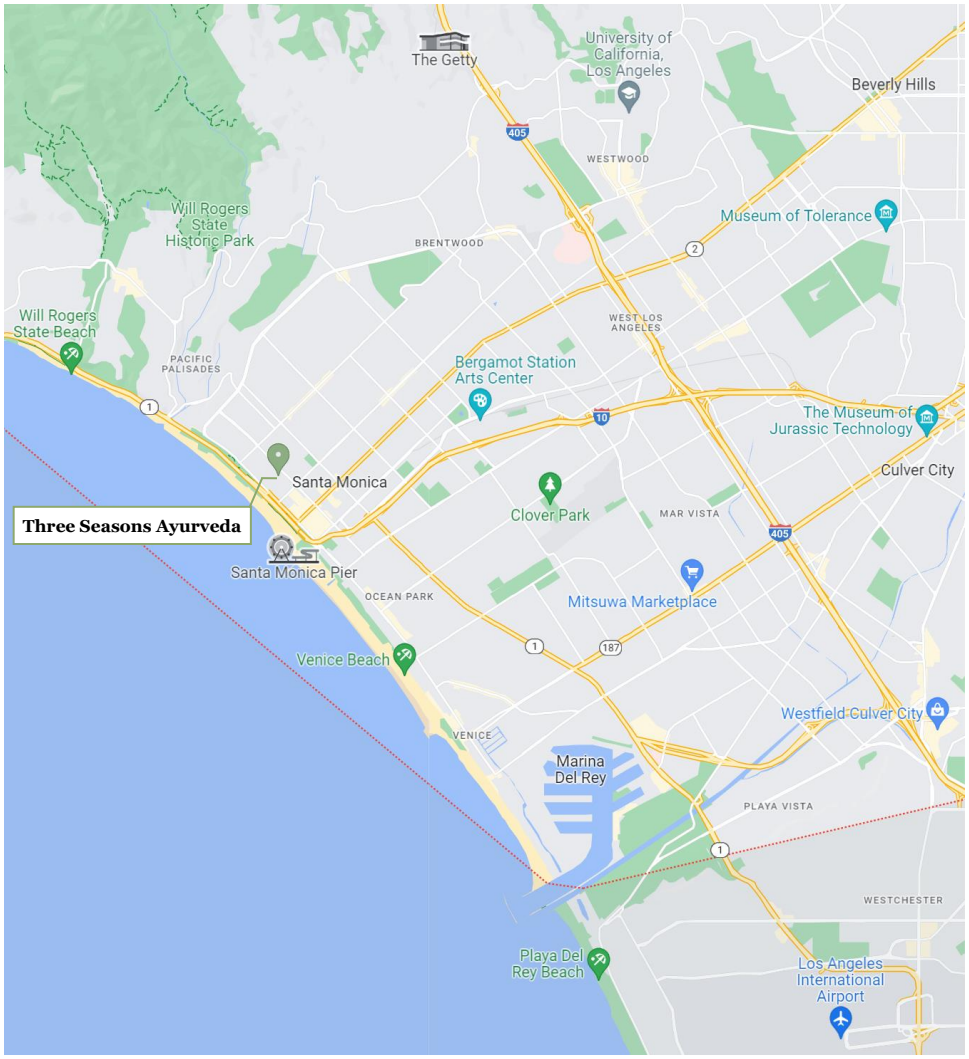
Address:
1033 3rd St. #309
Santa Monica, California
90403

Direction:
Take Interstate 10 (Santa Monica Fwy) towards the ocean and exit the 4th Street exit, then turn right on 5th Street going north.

Continue past Colorado, Broadway, and Santa Monica Boulevards, and turn left on Wilshire Boulevard, heading towards the ocean.

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

Parking:
I have parking available, so please call (310-339-8639) upon your arrival, and I will direct you to the parking space.



Ayurveda

The Journey to Holistic Health

Gotu Kola

Ayurveda, "The Science of Life," is the original medical system of India and is considered the mother of all other medicines. Where traditional medicines look to specific diseases and symptoms, Ayurveda considers the complete person, body, mind, and spirit and then treats the root cause of the disharmony.

Ayurveda is based on the five elements (ether, air, fire, water, and earth) found in the universe and is understood by their connection to the three biological energies, doshas (Vata, Pitta, and Kapha), that are found in our bodies. We all have a unique combination of these doshas, which determine our constitution (true natures). Imbalances are experienced when our environments change (seasons or locations) from what we digest and our mental and emotional states.

Ayurveda defines wellness as "the absence of disease" when all the bodily systems, tissues, organs, and functions maintain health and wellness despite potential illness-causing influences. Health and well-being are achieved by clearing disturbances and balancing metabolic and energetic patterns using therapies and practices connected to the five elements through the five senses (taste, touch, smell, hearing, and sight).

Ayurveda only uses natural processes and methods to bring wellness and restore good health. Modern medicine attempts to restore health by treating the body's symptoms or attacking the disease with artificial drugs and medications that treat the symptoms and not the root cause of the disturbance. Ayurveda complements traditional medical practices and does not replace medical diagnosis and treatment but works with Western medicine to bring balance and wellness.

Three Seasons Ayurveda works with clients through a collaborative process, establishing a plan to achieve your health and wellness objectives through holistic methods, incorporating lifestyle, diet, herbal preparation, and physical and spiritual practices.

Jeff Perlman Bio

Jeff studied nutrition and health in college before attending the Cordon Bleu in France and worked as a chef for 15 years. He was introduced to Ayurveda during yoga teacher training and graduated from California College of Ayurveda and The Ayurvedic Institute. He established Three Seasons Ayurveda (a licensed holistic medical practice and herbal dispensary) in Santa Monica in 2010 and is a Nama Professional Practitioner, a Certified Panchakarma Specialist, an Aroma and Marma Therapist, a Registered Clinical AHG Herbalist, a Certified Iyengar Yoga instructor, IAYT and Nama Ayuryoga Therapist and Licensed California Massage Therapist.

Confidential Health History Questionnaire

Instructions: Please complete the Health History questionnaire as thoroughly as possible, knowing that all information contained here is confidential and will not be shared with anyone without your permission. Please bring any relevant medical results with you to your first appointment.

Date: MM/DD/YYYY

Client Information

Name: _____

Address: _____

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

Email: _____ **Phone:** (Primary) _____

Date of Birth: _____ **Age:** _____

Occupation: _____

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

Handed: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Partner Status: - Please select here - **No. of Children:** _____ **Ages:** _____

Emergency Contact: _____ **Phone:** _____

Referred by: _____

Objectives

What are your three main objectives to achieve with Ayurveda?

1. _____
2. _____
3. _____

Health

Primary Physician: _____

City/State: _____

Date of last physical exam: _____

Any abnormal blood results (cholesterol, thyroid, glucose, blood pressure, vitamin or mineral deficiency)**?**

Please submit current blood tests or applicable medical information if available.

Do you have any infectious diseases? ☐ Yes ☐ No

If *Yes*, describe: _____

Do you have any allergies (medications, food, drugs, environment, etc.)**?** ☐ Yes ☐ No

If *Yes*, describe: _____

Health Concern

List of Health Concern/s	Date Started	Diagnosed by

Past Medical History

Please list any serious illnesses, hospitalizations, or surgeries.

Condition/Procedure/Treatment	Date

Have you had any cosmetic surgeries? ☐ Yes ☐ No

If *Yes*, provide details: _____

Do you see any healthcare professionals (mental health, naturopathic, chiropractor, acupuncturist, massage therapist, etc.)**?** ☐ Yes ☐ No

If *Yes*, provide details below:

Healthcare Professional/s	How Often

Family History

If deceased, please list the age at the time of death & cause.

Relationship	Age	Health Concern
Grandfather (*Father's side*)		
Grandmother (*Father's side*)		
Grandfather (*Mother's side*)		
Grandmother (*Mother's side*)		
Father		
Mother		
Sibling		
Sibling		
Sibling		

What countries did your ancestors live in before they came to the USA?

_____

Substance Usage

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If *Yes*, what do you prefer to drink? _____

How often? ☐ Daily ☐ Several times a week ☐ Several times a month ☐ Seldom

Smoking

Have you ever smoked? ☐ Yes ☐ No

If *Yes*, when did you quit? _____

Do you currently smoke? ☐ Yes ☐ No

If *Yes*, for how long? _____

How many cigarettes per day? _____

Drugs

Are there any recreational drugs you have taken in the past or are currently taking? ☐ Yes ☐ No

If *Yes*, describe:

Sleep

How many hours do you sleep in 24 hours? _____

What time do you normally go to bed? _____

What time do you normally awaken? _____

What is the quality of your sleep?

☐ Disruptive (awake with a swirling mind)

☐ Soundly and ready to go upon awakening

☐ Awakening is difficult and slow (feel sluggish)

Do you feel refreshed upon awakening?

☐ Always ☐ Most days ☐ Half the time ☐ Never

Work and Creativity

What is your Occupation? _____

Please rate your work life (1= least 5= most)	**1**	**2**	**3**	**4**	**5**
Level of stress	☐	☐	☐	☐	☐
Level of work satisfaction	☐	☐	☐	☐	☐

What are your Creative Interests (painting, gardening, cooking, writing, etc.)**?**

Exercise

Do you exercise regularly? ☐ Yes ☐ No

If *Yes*, describe:

Type (e.g.: running, swimming, yoga, etc.)	**Length of time**	**Times per week**

Relationship

Who is your primary intimate relationship? _____

Please rate your relationship (1= least 5= most)	**1**	**2**	**3**	**4**	**5**
Level of stress	☐	☐	☐	☐	☐
Level of work satisfaction	☐	☐	☐	☐	☐

How often do you engage in sexual activity (with a partner or masturbation)**?**

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Religion and Spiritual

What religion were you brought up with? _____

Do you have a religious practice (church, temple, etc.)**?** ☐ Yes ☐ No

If *Yes*, describe: _____

Do you have a spiritual practice (yoga, meditation/pranayama, etc.)**?** ☐ Yes ☐ No

If *Yes*, describe: _____

Addiction

Do you have any current or past addictions (food, drugs, sex, gambling, etc.)**?** ☐ Yes ☐ No

If *Yes*, describe:

Men

Do you have any prostate issues? ☐ Yes ☐ No

If *Yes*, describe: _____

Do you get up nightly to urinate? ☐ Yes ☐ No

If *Yes*, how many times? _____

Check if you experience any of the following: Select all that apply.

☐ Urinary force decreases ☐ Difficulty emptying the bladder

☐ Difficulty with ejaculation ☐ Difficulty with erection

Women

Are you pregnant? ☐ Yes ☐ No

If *Yes*, when is the due date? _____

Have you had a hysterectomy? ☐ Yes ☐ No

If *Yes*, when? _____

Do you use birth control? ☐ Yes ☐ No

If *Yes*, what type? _____

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

Regularity: ☐ Irregular ☐ Variable ☐ Regular

Flow: ☐ Variable ☐ Light ☐ Moderate ☐ Heavy

Discomfort: ☐ Mild ☐ Moderate ☐ Painful

What is your normal length of menstrual cycle? No. of days (e.g.: 3-5)

Describe gynecological problems: _____

Schedule and Travel

Document your daily routines.

Routines	Time	Activity
Morning		
Afternoon		
Evening		

Do you have a daily commute? ☐ Yes ☐ No

If *Yes*, describe: _____

Do you travel regularly)? ☐ Yes ☐ No

If *Yes*, describe: _____

Food and Beverage

Food

Do you like to cook? ☐ Yes ☐ No

What type of foods do you prepare?

☐ from scratch ☐ mostly prepared foods ☐ frozen or canned ☐ microwave

Classify yourself as an eater:

☐ carnivore ☐ vegetarian ☐ vegan ☐ pescatarian ☐ omnivore

Do you eat dairy products/cheese? ☐ Yes ☐ No

Do you have food sensitivities (Gluten, lactose, other allergens, etc.)**?** ☐ Yes ☐ No

If *Yes*, describe:

Do you experience emotional eating? ☐ Yes ☐ No

If *Yes*, describe: _____

Which do you like? Select all that apply.

☐ sweet ☐ sour ☐ salty ☐ spicy ☐ bitter ☐ astringent

☐ fried ☐ creamy ☐ crunchy ☐ heavy ☐ light

Describe your meals or usual food choices. Be specific.

Meals and Snacks	
Breakfast	
Lunch	
Dinner	
Snacks	

Beverage

How many cups (1 cup = 8oz) **of the beverages below do you drink per day?**

Beverage	No. of cups	Beverage	No. of cups	Beverage	No. of cups
Water		Tea, Herbal		Soda	
Water, Sparkling		Tea, Caffeinated		Soda, diet	
Coffee		Coffee, Decaffeinated		Coconut Water	
Milk, Dairy		Milk, Alternative		Juice	
Other (describe):					

Current Health Concern

Please indicate any physical and emotional patterns you have had in the last 3 months.

Below, assign a ***Frequency*** (with a letter) and an ***Intensity*** (with a number 1 to 10) in the tables below.

Frequency (F)	
C	Constant
D	Several times a day
W	Several times a week
M	Several times a month

Intensity (I)	
1-3	Mild discomfort
4-7	Moderate discomfort
8-10	Severe discomfort

Digestion

	F	I		F	I		F	I
Abdominal pain	☐	☐	Burning Indigestion	☐	☐	Nausea	☐	☐
Excessive Gas	☐	☐	Heartburn	☐	☐	Vomiting	☐	☐
Belching	☐	☐	Acid reflux	☐	☐	Slow	☐	☐
Bloating	☐	☐	Smelly gas	☐	☐	Sluggish after eating	☐	☐
Erratic	☐	☐	Ulcers	☐	☐	Sleepy after eating	☐	☐

Elimination

Do you have a daily bowel movement? ☐ Yes ☐ No

If *Yes*, how many times per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4

If you miss days, how many days are usual? _____

	F	I		F	I		F	I
Constipation <1bm/day	☐	☐	Diarrhea	☐	☐	Mucus in stools	☐	☐
Hard & Dry Stool	☐	☐	Loose Stools	☐	☐	BM only after meals	☐	☐
Constipation & Diarrhea	☐	☐	Bloody stool	☐	☐	Smooth/Easy	☐	☐
Rectal Pain	☐	☐	Hemorrhoids	☐	☐			

Condition of stool:

☐ sink ☐ float ☐ bloody ☐ mucous ☐ no odor ☐ odor

Color of stool:

☐ dark ☐ medium ☐ light

Psychology

	F	I		F	I		F	I
Worry	☐	☐	Irritable	☐	☐	Lethargy	☐	☐
Anxiety	☐	☐	Anger	☐	☐	Sadness	☐	☐
Fear	☐	☐	Resentment	☐	☐	Depression	☐	☐
Overwhelm	☐	☐	Jealousy	☐	☐	Over attachment	☐	☐
Spacey	☐	☐	Envy	☐	☐	Grief	☐	☐
Insomnia	☐	☐	Critical of other	☐	☐	Procrastination	☐	☐
Indecisive	☐	☐	Critical of self	☐	☐	Foggy feeling	☐	☐
Loss of balance	☐	☐	Intense	☐	☐	Poor mental clarity	☐	☐
Poor memory	☐	☐	Sharp	☐	☐	Melancholy	☐	☐

Life's Pattern

Looking back through your life, choose the statement that explains your *Entire Life*. Select all that apply.

Appetite:
- ☐ Eat frequently; hunger is variable, and I can forget to eat.
- ☐ Strong appetite, do not skip meals and prefer three meals per day.
- ☐ Prefer to eat 2-3 times daily, but can go without eating.

Working on projects:
- ☐ Like to start but completion is difficult.
- ☐ Completion is imperative.
- ☐ Like working on projects, but prefer others are in charge.

Decision making:
- ☐ Change mind frequently.
- ☐ Make decisions easily, can change my mind with new info.
- ☐ I take my time and consider all information.

Approach to routine:
- ☐ Dislike routine, hard to establish regularity.
- ☐ Enjoy planning, organizing, and structure.
- ☐ Prefer the safety of routine.

Mood:
- ☐ Swings up and down, anxious.
- ☐ Critical, judgmental and can be angry.
- ☐ Melancholy, lack of desire and depressive.

Interact with other people:
- ☐ Most often, I prefer to go off on my own.
- ☐ Most often the leader.
- ☐ Most often a follower and refer supportive roles in groups.

Stress:
- ☐ Under stress, I often become worried or overwhelmed.
- ☐ Under stress, I often become irritable but rise to the challenge.
- ☐ Under stress, I often withdraw to observe or become reclusive

Body temperature:
- ☐ My hands and feet are often cold, I prefer warm climates.
- ☐ I am warm most of the time, no matter the climate.
- ☐ I adapt easily to most conditions but tend to feel cooler.

Sleep pattern:
- ☐ Sleep lightly, awaken easily, difficult to go back to sleep.
- ☐ Sleep soundly and awaken with ease, ready to go.
- ☐ Sleep is deep and long, it is difficult to awaken, and feel groggy.

When I skip a meal, I feel:
- ☐ Lightheaded and anxious.
- ☐ Critical, irritable and angry.
- ☐ Does not bother me.

When balanced, I feel:
- ☐ I feel energetic, creative, and enthusiastic.
- ☐ I feel perceptive, disciplined, and logical.
- ☐ I feel nurturing, calm, and devotional.

Weight:
- ☐ Can be underweight, do not gain weight easily.
- ☐ Stays normal, easy to gain and loose.
- ☐ Can be overweight, hard to lose weight.

Speech:
- ☐ Enthusiastic, can ramble, and veer off topic easily.
- ☐ Clear, opinionated, and can be sharp and louder.
- ☐ Normally slow, sweet, pleasant, and quitter.

Friends:
- ☐ Know a lot of people, but few close friends.
- ☐ Very selective, have warm friendships, make enemies easily.
- ☐ Loyal, reliable, with many friends.

Medication, Herbal Products, and Supplements

Medication, Herbal Product and Supplement	Who Prescribed? (Doctor, Practitioner, Self)	Dosage (Amount/How often)	Date Started

Additional Information

Informed Consent

The National Institute of Health Office of Complementary and Alternative Medicine considers Ayurveda a form of complementary and alternative medicine in the United States. In the State of California, Ayurveda is a non-licensed profession, and its practice was legalized under the passage of Senate Bill 577.

Jeff Perlman, the principal of Three Seasons Ayurveda, is not a medical doctor but is certified by the National Ayurvedic Medical Association, the American Herbalist Guild, the National Association of Nutritional Professionals, the California Massage Therapy Council, the International Association of Yoga Therapists, and the American Culinary Association.

Ayurveda works directly with Western medicine, and Three Seasons Ayurveda will not alter any medications without the approval of your Medical doctor. While we take blood pressure, vital signs and perform some Western diagnostic techniques, this information is used to determine Ayurvedic health markers.

Your program starts by determining your unique constitution, which is the starting point to establish your holistic health program, which may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aromatherapy, massage therapy, and other natural therapeutics.

Three Seasons Ayurveda maintains the highest standard of confidentiality, and personal information would only be shared at the client's request.

I acknowledge that Jeff Perlman and Three Seasons Ayurveda are not medical physicians, pharmacists, or nurse practitioners and cannot legally diagnose, prescribe, treat, or claim to cure diseases. By signing this document, I understand that I have been advised of all risks, contradictions, and benefits of holistic treatments and release Jeff Perlman and Three Seasons Ayurveda from any responsibility.

Signature _____ Date MM/DD/YYYY

Financial Policy Agreement

1. All fees are due at the time of service.
2. There is a $85 fee for cancellations without 24-hour notice.
3. Fees are refundable 24 hours before your appointment.
4. Three Seasons Ayurveda accepts all credit cards, Venmo, Zelle, checks, and cash.
5. Three Seasons Ayurveda does not bill insurance companies.

I have read and understand the financial policies outlined above.

Signature _____ Date MM/DD/YYYY

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