

Three Seasons Ayurveda



A Holistic Health Practice

Thank you for choosing Three Seasons Ayurveda for your holistic health care needs. Please review the information below, and fill out the Confidential Health History questionnaire with as much detail as possible before your visit. Return paperwork no later than 24 hours before your first appointment via mail, scan, and email, or photo and email.

Please let me know if you have any questions or concerns, and I will look forward to your first appointment.

Jeff Perlman

Clinical Ayurvedic & Panchakarma Specialist. Certified AHG Clinical Herbalist, California Massage Therapist, Marma and Aroma Therapist, Iyengar Yoga Instructor, IAYT Yoga Therapist, and Nama Ayuryoga Therapist.

Three Seasons Ayurveda

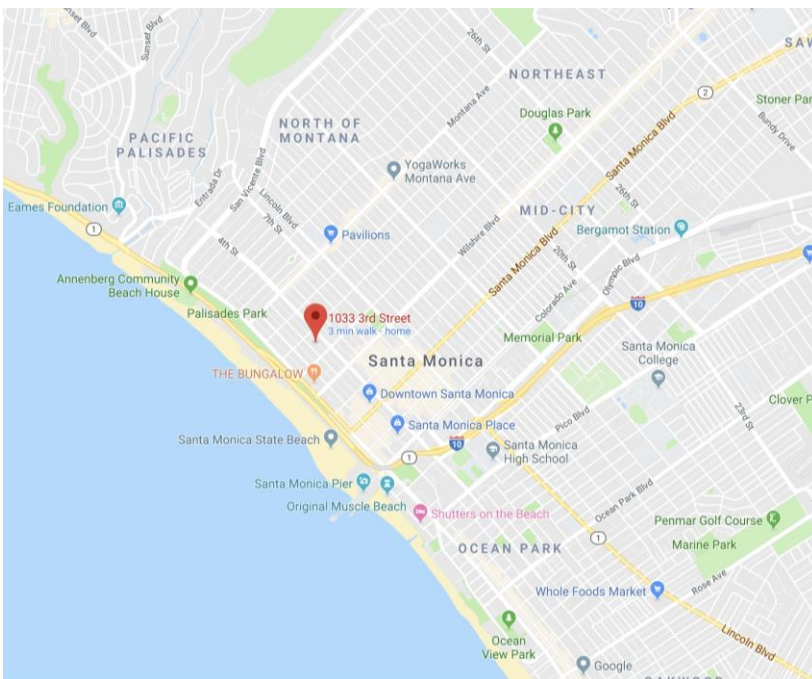
1033 3rd St. #309

Santa Monica, California 90403

310-339-8639

jeff@tsayurveda.com

www.threeseasonsayurveda.com



Directions from the East

Take Interstate 10 (Santa Monica Fwy) towards oceans and exit 4th street, 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 coming to 1033 3rd Street.

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

Ayurveda

The Journey to Holistic Health

Ayurveda is defined as the "Knowledge of Life" and is the ancient healing system of India practiced for thousands of years. It differs from other medical systems by looking to the whole person, body, mind, and spirit and treating the root cause, not just symptoms.

Ayurveda defines wellness as the absence of disease. When all bodily tissues, organs, systems, and functions act together healthily, we maintain health and wellness despite potential illness-causing influences. Ayurveda believes that by balancing the mind-body connections and functions, the body's natural intelligence will automatically bring itself to wellness.

According to Ayurveda's principles, everything in the universe comprises the five elements; ether, air, fire, water, and earth. These forces work within nature and are the same forces that are at work within us. Once we identify these forces, we use the five elements which are connected to the five senses (sight, hearing, smell, taste, and touch) to bring balance and harmony to the body, mind, and soul.

This is achieved by applying opposite qualities to that which needs healing. If, for example, you are overheated, your therapies may be cooling in nature. If your life is too fast-paced, you may need to slow down and find groundedness. If your digestion is sluggish, it may need to be stimulated.

The first step is to determine your Prakruti (constitution), which is your Ayurvedic "genetic" footprint, which explains your true nature and makeup. Once you know this, holistic healing practices can be determined and initiated. The process of understanding this requires an Ayurvedic evaluation, which encompasses two appointments about one week apart.

At the first appointment (Initial Consultation), you will have an Ayurvedic physical exam. We will go through your Confidential Health History, which documents your physical, mental, emotional, and spiritual characteristics and tendencies.

Approximately one week later we will meet again for your Report of Findings.

I will present in writing your Prakruti (constitution) and Vikruti (current state of health) results and a proposed treatment plan. Treatment programs include lifestyle practices, dietary and food programs, possible medicinal herbal formulas, and therapies associated with the five senses applicable to your health concerns.

At this point, you will have all the information required to decide how to proceed with your holistic health care program. In most cases, follow-up appointments are suggested initially to establish continuity and then seasonally reviewing progress, challenges, and integrating new practices and goals.

I realize that your health is deeply personal and profoundly important. Please be assured that I do not undertake this lightly. I work closely with each of my clients in a respectful, confidential, dedicated manner. Thus, your healing becomes a joint effort, utilizing expertise and insight along with your willingness and commitment.

I will look forward to working with you. I am honored to bring Ayurveda's time-honored wisdom to you as I assist you on your healing journey.

CONFIDENTIAL CLIENT HISTORY

Name: _____

Address: _____

City, State: _____ Zip: _____

Telephone-Primary: _____

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

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

Emergency Contact Name & Number: _____

Referred By: _____

Family Physician: _____

Height: _____ Current Weight: _____ Goal Weight: _____

Are you right or left-handed? _____

What are your three initial objectives to achieve with Ayurveda:

1. _____

2. _____

3. _____

Please tell me your major health concerns?

1. _____

When did it start? _____ Diagnosed by: _____

2. _____

When did it start? _____ Diagnosed by: _____

3. _____

When did it start? _____ Diagnosed by: _____

Date of last physical examination? _____

Any abnormal blood test results? (Cholesterol, thyroid, vitamin deficiency)

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

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

Name: _____

For what condition? _____

Name: _____

For what condition? _____

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. _____

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

Family Medical History

If deceased please list age at time of death & cause

Relationship	Age	Health Problems
Fathers – Father		
Fathers – Mother		
Mothers – Father		
Mothers – Mother		
Father		
Mother		
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?

What is your Occupation? _____

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

CURRENT HEALTH CONCERNS

Please indicate any Digestive, Elimination and Psychological patterns that you have by assigning:

<p><u>Frequency (With a Letter)</u> C = Constant D = Daily W= Weekly M= Monthly</p>
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<p><u>Intensity (Number 1 to 10)</u> 1 to 3 = Mild discomfort 4 to 7 = Moderate discomfort 8 to 10 Severe discomfort</p>
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<u>Digestion</u>								
	<u>F</u>	<u>I</u>		<u>F</u>	<u>I</u>		<u>F</u>	<u>I</u>
Excess gas			Burning indigestion			Nausea/Vomiting		
Belching			Acid reflux			Sluggish after eating		
Bloating			Heartburn			Poor appetite		
<u>Elimination</u>								
	<u>F</u>	<u>I</u>		<u>F</u>	<u>I</u>		<u>F</u>	<u>I</u>
Constipation			Diarrhea			Mucus in stool		
Constipation & diarrhea			Loose stools			Bm only after meal		
Rectal pain			Hemorrhoids					
<u>Psychology</u>								
	<u>F</u>	<u>I</u>		<u>F</u>	<u>I</u>		<u>F</u>	<u>I</u>
Worry/Anxiety			Irritable			Lethargy		
Overwhelm			Anger / Rage			Sadness		
Indecisive			Intense / Sharp			Depression		
Fear			Resentment			Over Attachment		
High stress			Criticalness			Procrastination		

Male Conditions

Urinary Force Decrease Yes No Burning Urination Yes No
 Problems Emptying Bladder Yes No Difficulty with Ejaculation Yes No

Female Conditions

Birth Control: Yes No Type: _____ 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)

Flow: Variable Light Moderate Heavy Discomfort: Mild Moderate Painful

Describe gynecological problem: _____

Do you exercise regularly? Yes No

Types: _____ Length of time: _____ Times per week: _____

Types: _____ Length of time: _____ Times per week: _____

Types: _____ Length of time: _____ Times per week: _____

Do you currently smoke?

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

Have you ever smoked? Yes No if yes, when did you quit? _____

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

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

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

Dietary patterns: (Food choices and meal times) **BE SPECIFIC**

<u>Meal</u>	<u>Time (s)</u>	<u>Typical food and beverages</u>
Breakfast		
Snack		
Lunch		
Snacks		
Dinner		
Snacks		

Do you experience emotional eating?

Food choices: _____

Your Characteristics and Tendencies

Question	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
My appetite is	I like to eat often		I prefer to eat 3x day		I forget to eat	
When I miss a meal, I feel	Unsettled, cranky, anxious		Irritable, angry, impatient		It does not bother me	
After eating, I feel	Gassy and/or bloated		Heartburn or acidity		Heavy & sleepy	
My weight history is	I do not gain weight easily		I gain and lose weight easily		I gain and lose weight slowly	
My elimination is	Irregular, 0-1 bm day		Regular, 1-2 bm day		Slow & easy, 1 bm day	
My body temperature is	Hands and feet cold, prefer warm climates		Fell warm usually, no matter climate		Cool most of time, adapt to all climates	
When I start a project, I	Like to start, difficulty finishing		Completion is imperative to me		Good worker, but do not start them	
When making decisions, I am	Changeable, scattered, difficult		Easy, but can change mind with more info		Take time, do not feel pressure	
When stressed, I feel	Anxious, worried, & overwhelmed		Irritable, but rise to challenge		Withdrawal & reclusive	
When balanced, I feel	Creative & enthusiastic		Focused & logical		Calm, nurturing & devotional	
My skin is	Dry & rough		Reddish, inflamed & flush easily		Thick, smooth, pale & damp	
My sleep pattern	Light, awaken easily, hard to go back to sleep		Sleep soundly & awaken with ease		Sleep deeply, difficult to awake	

Any final information or considerations you would like to share?

Financial Policy Agreement

Three Seasons Ayurveda

1. The complete Ayurvedic evaluation is two appointments. The first appointment (Initial consultation) and second appointment (Report of Findings) can be done either in person or virtually. Full payment is due at the first appointment.
2. All appointments are paid at the time of service.
3. A 50% deposit guarantees body therapy appointments at the time of scheduling.
4. There are additional charges for herbal formulations and other services or products.
5. Additional shipping charges may apply.
6. Payment is by cash, check, Venmo, or credit card.
7. Three Seasons Ayurveda does not bill insurance companies for any services.

I have read and understood the financial policies outlined above.

Signature (*type or sign*) _____ 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 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 complementary and alternative medicine in the US. In the state of California, Ayurveda is a non-licensed profession. Its practice was legalized under the passage of Senate Bill 577 in 2003. Ayurvedic consultations are considered alternative or complementary to healing arts that are 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 take blood pressure, vital signs and perform some examination techniques similar to a routine medical examination, we evaluate 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.

Signature (*type or sign*) _____ Date: _____