Blue Lotus Healing Center, LLC

2040 East Maple Avenue Flint, MI 48507 810.620.1000

Contact Information

Name: _____ Date: _____ / _____ / _____

Home address: _____ Suite/Apt#: _____

City: _____ State: _____ Zip: _____

Daytime phone: (_____) _____ Evening: (_____) _____

Cell: (_____) _____ Email: _____

Personal Information

Date of Birth: _____ / _____ / _____ Time of birth (if known): _____

Place of birth: City:_____State:_____ Country: _____

Age: _____ Occupation: _____ Marital status: _____

Children/ages:_____

Objectives

Check the items that reflect your main objectives.

☐ I would like an alternative approach for managing my health.

☐ I would like to improve my lifestyle and dietary practices to improve my health.

☐ I would like to change my habits and behavioral patterns to improve my relationships.

☐ I would like to manage stress, tension, and worry to attain a more stable emotional state.

☐ I would like to:_____

Are you currently under a physician's care for a specific medical problem? ☐ Yes ☐ No

If yes, what? _____

Concerns

Please describe the conditions that are currently bothering you (use an additional page if necessary):

_____

_____

_____

_____

How long have your present concerns troubled you?: _____

What would you like to achieve or change in terms of your health and wellness?:

_____

_____

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Last Physical Exam

Date: _____ Blood pressure: _____ Cholesterol: _____

Height: _____ Weight: _____ Weight changes: _____

What prescription drugs or medications are you currently taking (how often, how many years, dosing)?:

Name of drug/herbal/vitamin	Reason	Dosing	Frequency/day	Before/after meals

Psychosocial

Financial problems: ☐ Major ☐ Average ☐ Minor

Work or school adjustments: ☐ Difficult ☐ Easy

Marital status: ☐ Single ☐ Partner ☐ Married ☐ Widow ☐ Divorced

Marital adjustments: ☐ Difficult ☐ Easy

Are you sexually active?: ☐ Yes ☐ No Frequency? _____

Have you ever contracted a sexually transmitted illness?: ☐ Yes ☐ No

If yes, what and when?: _____

Method of birth control: _____

Sexual difficulties: _____

Nervous tension: ☐ Major ☐ Average ☐ Minor

Reasons for nervous tension: _____

Significant life events: (i.e. moving, divorce, death): _____

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Personal History

Do you or your family members have a history of:

Condition	SELF	RELATIVE Maternal	RELATIVE Fraternal	Condition	SELF	RELATIVE Maternal	RELATIVE Fraternal
Food allergies				Stroke			
Drug allergies				CVA			
Dental complications				Cancer			
Bleeding gums				Chemo Rx			
Contact lenses				Radiation Rx			
Glaucoma				Hepatitis A			
Eye surgery				Hepatitis B			
Pain in the ear				Hepatitis non A/B			
Ringing in ear				Mononucleosis			
Shortness of breath				Jaundice			
Asthma				Anemia			
Pneumonia				Gallstone			
Tuberculosis				Kidney dialysis			
High blood pressure				Kidney stones			
Low blood pressure				Bladder dialysis			
Dizziness				Thyroid disease			
Fainting				Thyroid medication			
Seizures				Ulcers			
Convulsions				Intestinal bleeding			
Diabetes				Chronic constipation			
Feet/ankle swelling				Recurring diarrhea			
Chest pain				Arthritis			
Angina				Implant			
Heart murmur				Prosthesis			
Heart attack				Prolonged bleeding			
Heart disease				Venereal disease (STD)			
Heart surgery				HIV exposure			
Rheumatic fever				Psychiatric Rx			
				Sleep disorder			

History of any other disease or problems? (Please list any other illnesses, surgeries, trauma, emotional stresses, mental stresses, lifestyle conditions, addictions, alcohol, drug abuse, weight changes, or anything else that can help us understand your health condition): _____

_____

_____

Family History: Any other family illnesses?: _____

_____

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Check all that apply currently and within the last six months:

Digestion	☐ Irregular with ☐ Bloating ☐ Gas/Flatulence ☐ Abdominal Discomfort ☐ Gurgling Intestines ☐ Breathlessness	☐ Quick digestion with ☐ Acid Indigestion ☐ Heartburn ☐ Burning pain ☐ Still hungry after eating ☐ Nausea ☐ Vomiting	☐ Slow digestion with ☐ Feeling of heaviness ☐ Lethargy ☐ Sleepy after eating ☐ Low energy after meals ☐ Excess mucous secretions
Appetite	☐ Irregular ☐ Sometimes eat at midnight ☐ Excess hunger ☐ Sharp hunger	☐ Desire to eat large amount of food ☐ Strong unbearable appetite ☐ Feels hypoglycemic	☐ Emotional eating (no urge for food but you still eat) ☐ Dull / No appetite
Cravings	☐ Fried food ☐ Hot spicy food ☐ Meat or other protein	☐ Sweets ☐ Cooling foods & drinks	☐ Hot, sharp, dry & spicy food ☐ Wine or alcohol
Elimination	☐ Tendency toward constipation ☐ Dry ☐ Irregular	☐ Defecate without satisfaction ☐ Pass gas during elimination	☐ Loose stools ☐ Diarrhea ☐ Mucous in stool
Pain	☐ Shifting ☐ Tearing ☐ Moving ☐ Vague ☐ Throbbing ☐ Colicky ☐ Cutting	☐ Excruciating with breathlessness, fear and tachycardia ☐ Burning ☐ Sharp ☐ Hot ☐ Migraine headaches	☐ Sucking pain with fever, nausea and irritability ☐ Intense pain ☐ Dull ☐ Stable ☐ Deep dull aching pain ☐ Can sleep through the pain
Skin	☐ Dry ☐ Cracked ☐ Rough ☐ Thin ☐ Discolored ☐ Patchy ☐ Hives	☐ Rash ☐ Urticaria ☐ Acne ☐ Tender ☐ Warm/hot to touch ☐ Redness ☐ Boils	☐ Ruddy ☐ Itchy ☐ Excess oily ☐ Thick ☐ Pallor ☐ Cold/clammy ☐ Lustrous
Sleep	☐ Insomnia ☐ Need night light ☐ Restless ☐ Difficulty falling asleep	☐ Interrupted sleep ☐ Must have complete darkness ☐ Needs to read/TV to sleep	☐ Excess sleep ☐ Daytime napping ☐ Heavy sleeper ☐ Slow to awaken ☐ Hypersomnia

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Check all that apply currently and within the last six months:

Seasonal Allergies	☐ Breathlessness ☐ Wheezing ☐ Constricted Breathing ☐ Rash	☐ Itching eyes ☐ Hives ☐ Irritation ☐ Inflammation	☐ Runny nose ☐ Watery eyes ☐ Congestion
Food Sensitivity	☐ Night shades ☐ Leftovers	☐ Dry fruits ☐ Raw food ☐ Hot spicy foods	☐ Sour foods ☐ Fermented foods ☐ Dairy products
Sweating	☐ Scanty or no sweat	☐ Excess ☐ Profuse with body odor	☐ Cold/clammy
Muscle Reactivity	☐ Twitching ☐ Cramping ☐ Weakness ☐ Numbness ☐ Tingling	☐ Spasms ☐ Bruising ☐ Tenderness to touch ☐ Sore ☐ Excess heat	☐ Tumors ☐ Cysts ☐ Growths ☐ Generalized weakness
Bone and Joints	☐ Painful ☐ Popping ☐ Cracking ☐ Stiffness ☐ Loose ☐ Osteopenia ☐ Osteoporosis ☐ Medical fractures	☐ Scoliosis ☐ Inflamed ☐ Hot / feverish ☐ Tender ☐ Inflammatory arthritis ☐ Osteomyelitis ☐ Bursitis	☐ Swollen joints ☐ Bone tumors ☐ Bone spurs ☐ Osteosarcoma ☐ Non-inflammation with profuse infusion ☐ Sclerosis
Circulation	☐ Cold extremities (hands, feet)	☐ Burning hands / feet ☐ Bruises easily ☐ Tendency toward bleeding	☐ Cold clammy hands ☐ Varicose veins ☐ Thrombotic element
Body Weight	☐ Variable ☐ Can't gain weight ☐ Thin or slender	☐ Stable ☐ Tendency toward hyper metabolism	☐ Tendency to easily gain weight ☐ Overweight ☐ Obese ☐ Voluptuous ☐ Stout

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Check all that apply currently and within the last six months:

General Symptoms	☐ Dry cough ☐ Ringing ears ☐ Light-headed ☐ Dryness: external/internal ☐ Hemorrhoids: external/ nonbleeding ☐ Low backache ☐ Irregular metabolism ☐ Dry mouth ☐ Receding gums ☐ Blackish brownish discoloration ☐ Fatigue ☐ Lack of power, tone & strength ☐ Paralysis	☐ Slipped disc ☐ Hernia ☐ Spontaneous bleeding ☐ Hyper-sensitive to smells ☐ Hair loss ☐ Excess thirst ☐ Hemorrhoids: internal/ bleeding ☐ Hot flashes ☐ Tendency toward inflammatory conditions ☐ Acidic saliva ☐ Hyper acidity ☐ Yellowish discoloration	☐ Fainting ☐ High metabolism ☐ Cold ☐ Cough ☐ Congestion ☐ Excess urination ☐ Frequent urination ☐ Fibrocystic ☐ Over salivation ☐ Edema ☐ Slow metabolism ☐ Albuminuria ☐ Lipoma(s) ☐ Cataracts
Mental-Emotional	☐ Transient Depression ☐ Inability to concentrate ☐ Forgetful ☐ Worry ☐ Fear ☐ Anxiety ☐ Insecurity ☐ Loneliness ☐ Nervousness ☐ Grief ☐ Restlessness ☐ Repetitive thinking ☐ Spacey	☐ Extreme depression with suicidal tendencies ☐ Anger ☐ Rage ☐ Resentful ☐ Judgmental ☐ Critical ☐ Envious ☐ Sharp tongued ☐ Vengeful ☐ Intolerant ☐ Irritable ☐ Aggressive ☐ Success-Failure mind set	☐ Seeks power, prestige and position ☐ Prolonged depression ☐ Sloppy ☐ Slow ☐ Confused ☐ Greed ☐ Attachment ☐ Mental lethargy ☐ Resistant to change ☐ Laziness ☐ Unforgiving ☐ Stubborn ☐ Boredom
Nature of response within relation-ships	☐ Talkative ☐ Uncertain ☐ Anxious ☐ Lonely ☐ Insecure ☐ Excitable ☐ Shy ☐ Spacey	☐ Seeks power, prestige and position ☐ Perfectionist ☐ Competitive ☐ Seeker of knowledge	☐ Based on acquiring comfort and pleasure

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Check your current digestive and psychological/emotional health challenges:

- ☐ Abdominal Pain
- ☐ Belching
- ☐ Regurgitation
- ☐ Gas
- ☐ Burning Indigestion
- ☐ Vomiting
- ☐ Nausea
- ☐ Heavy after eating
- ☐ Low energy after eating
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Unformed stool
- ☐ Rectal pain
- ☐ Bloody stool
- ☐ Mucous stool
- ☐ Unusual stool color
- ☐ Worry
- ☐ Anxiety/Fear
- ☐ Overwhelm
- ☐ Spacey
- ☐ Insomnia
- ☐ Self-destructive
- ☐ Irritable
- ☐ Anger
- ☐ Resentment
- ☐ Jealousy/Envy
- ☐ Critical
- ☐ Intense
- ☐ Sadness
- ☐ Depression
- ☐ Greediness
- ☐ Lethargy

What's your appetite like before eating (strong, so/so or poor)?: _____

_____

_____

How do you feel after eating (bloating, belching, fatigue, etc.)?: _____

_____

Do you currently engage in any exercise or physical activity?: ☐ Yes ☐ No

If yes, what kind?: _____

_____

Have you ever done yoga postures before? ☐ Yes ☐ No

If yes, what type(s) and how often?: _____

_____

List regular practices that are not included above, such as meditation, spiritual practices, etc.: _____

_____

_____

_____

Diet

Please describe foods that you typically eat:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water and Beverages: _____

Eating Routines: _____

Daily Routine

	Time	Activities	Variations
Morning			
Afternoon			
Evening			

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For Females

Age of onset of menses_____ Are you pregnant ☐ Yes ☐ No Months_____ # previous pregnancies _____

Difficult past pregnancies_____ Complications _____

Birth control ☐ Yes ☐ No What type _____

How long _____ Date last menstrual period_____ /_____ /_____

Length of cycle_____ ☐ regular ☐ irregular

Days between cycles_____ Flow ☐ heavy ☐ med ☐ light Color blood_____

Clots ☐ Yes ☐ No When_____ Pain and/or difficulty during cycle ☐ Yes ☐ No When_____

PMS symptoms: _____

Any other symptoms during cycle: _____

Yeast infections: _____

Urinary tract infections (frequency, duration): _____

Menopause stage/symptoms: _____

For Males

Prostate conditions_____ Other_____

Libido ☐ strong ☐ medium ☐ low Erections ☐ sustainable ☐ lost

Describe any other symptoms that you have regarding urination and/or sexual function _____

_____

_____

Notes

Use this space for anything else you would like to share:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Ayurveda is an ancient system of medicine focusing on the complete person including the body, mind and spirit. Ayurveda defines wellness as more than simply "the absence of disease". The Ayurvedic definition of health is when an individual's unique mixture of qualities, bodily functions, and five senses are balanced and the individual is able to experience peace, bliss, and joy in body, mind and spirit. Ayurveda recognizes that each person has a unique mind-body constitution. The Ayurvedic consultation process identifies the various components of an individual's constitution, determines where imbalances may exist, and provides education, guidance and options for helping the individual to regain balance and improve their health and wellness.

An Ayurvedic Consultation typically consists of three general steps:

1. **Assessment** – This includes a discussion of client concerns, reasons for the visit and the client's health history. The Practitioner will conduct an assessment of signs and symptoms of imbalance. Then the Practitioner and the client will discuss what the client is willing and able to do to achieve their stated healthcare goals.

2. **Findings** – The Practitioner will analyze the assessment results and compile information to determine the client's basic Ayurvedic constitution, the current state of imbalance, and the causative factor(s) involved.

3. **Recommendations** – The Practitioner will review their assessment and findings, and develop recommendations based on the client's unique needs, healthcare goals, and current state of imbalance. Recommendations may include information and instruction on diet and eating habits, lifestyle, yoga/exercise, meditation, breathing practices, herbal preparations, and other health improvement practices, as appropriate. The client and the Practitioner will refine the recommendations into a protocol that the client can realistically implement to achieve their healthcare goals.

Waiver of Liability

I, the undersigned, hereby confirm that I am consulting with Blue Lotus Healing Center, LLC at my own free will. I understand that there will be no diagnosis made, nor prescription given, but that Blue Lotus Healing Center, LLC will offer an assessment of my general health and will make dietary, herbal and nutritional recommendations to support my health. I understand the importance of frequent monitoring to revise the treatment protocol as required.

Signature: _____Date:_____

Print name: _____

All case history notes and medical information recorded during the consultation are kept strictly confidential.
Information contained herein will not be released to any person or agency except with your authorization or where required by law.