reena r. patel md, inc

AYURVEDA QUESTIONNAIRE

Only forms submitted by actual patients of REENA R PATEL MD INC will be reviewed.
Please do not fill out these forms if you are not an existing or new patient.

PERSONAL DATA:

Date: _____

Name: _____

E-mail address: _____

Address: _____

Telephone (home): _____

City: _____

Telephone (work): _____

State: _____ Zip Code: _____

Telephone (cell): _____

Country: _____

Fax number: _____

Gender: ☐ Male ☐ Female

Age: _____ Birth date: _____ Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you ALLERGIC to, or intolerant of, any HERBS, SPICES, FOODS, OR DRUGS? Please list below:

What are your goals for your wellness consultation today?

Do you currently engage in any activities that could compromise your health or would be considered “unhealthy”?

Do you have any current health concerns or problems?

Any significant previous health concerns or problems?

Any significant family history of health problems?

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Please list all prescription medications, birth control pills, hormone replacement therapy, vitamins or other supplements that you are taking:

Please list foods you typically eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

Any special dietary needs?

Previous Ayurvedic evaluations and treatments (if any):

List date and place of most recent previous Ayurvedic evaluation, if any:

List date and place of most recent in-residence Ayurvedic programs, if any:

BODY WEIGHT:

Height: _____ft. _____ in. Weight: Now _____, 1 year ago _____

Highest weight: _____ When? _____ Lowest weight: _____ When? _____

Any weight gain or loss in the past 6 months? (# of pounds, + or -) _____

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DIGESTION:

1. Is your digestion: ☐ Good ☐ Fair ☐ Poor
2. Is your appetite: ☐ Strong ☐ Moderate ☐ Mild ☐ Variable
3. In general, how is your energy during the day? ☐ Strong ☐ Medium ☐ Low ☐ Variable
4. Do you often feel heavy after eating? ☐ Yes ☐ No
5. Do you often feel sleepy after eating? ☐ Yes ☐ No
6. Do you have problems with (please circle):
   Gas flatulence belching bloating heartburn/acid reflux constipation diarrhea

   Other:_____
7. Are there any foods that cause discomfort? _____

ELIMINATION:

1. Do you bowel movement tend to be? ☐ Regular ☐ Irregular
2. How often do you have bowel movements? ☐ More than 3 times a day ☐ 2-3 times per day
   ☐ Once daily ☐ Less than once every 3 days
3. When do you usually have bowel movements?
   ☐ First thing in the morning ☐ Later in the morning ☐ In the afternoon
   ☐ Immediately after meals ☐ At night after dinner
4. Stools are usually: ☐ Soft ☐ Medium ☐ Hard ☐ Variable Consistency
5. Do you use enemas or laxatives? ☐ No ☐ Yes How often?_____
6. Do you have hemorrhoids? ☐ No ☐ Yes If yes, do they bleed? _____

DIET AND EATING BEHAVIOR:

1. Is your diet: ☐ Non-vegetarian ☐ Mostly vegetarian ☐ Vegetarian ☐ Vegan
2. Which is you main meal? ☐ Breakfast ☐ Lunch ☐ Dinner
3. Do you eat between meals? ☐ Yes ☐ No
4. How much time do you take for: Breakfast _____ Lunch _____ Dinner _____
5. Do you sit for 5-10 minutes after finishing a meal (circle one)? ☐ Yes ☐ No
6. Do you feel you now have or have had in the past an eating disorder? ☐ Yes ☐ No

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7. How often do you eat the following?

	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never
Leftovers?	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never
Frozen foods?	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never
Packaged foods/processed foods	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never
Cold foods and/or drinks?	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never
Raw vegetables (salad)?	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never
Red meat?	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never
Spicy foods?	☐ Often	☐ Sometimes	☐ Rarely	☐ Almost never

8. How many times per week do you eat out in a restaurant?

   _____

9. How often do you microwave your food or drinks? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
10. About what percentage of your food is organically grown or bought?_____
11. How many soft drinks or diet soft drinks do you drink each week? _____

SLEEP:

1. Is your sleep disturbed? ☐ Not all ☐ Somewhat ☐ Moderately ☐ Severely ☐ Very Severely
2. Do you take sleep aids? _____
3. What time do you usually go to bed (lights out)? _____
4. What time do you usually wake up? _____
5. Are your bedtime and arising times regular from day to day?

   ☐ Very Regular ☐ Mostly regular ☐ Somewhat regular ☐ Mostly irregular

PSYCHOLOGY:

1. How would you describe your mood?

   _____

2. Do you suffer from? (circle relevant) anxiety depression anger mood swings insomnia
3. Are you currently in psychological counseling? ☐ Yes ☐ No

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DAILY ROUTINE:

1. How regular is your daily routine (for example, do you go to bed, get up, and eat your meals around the same time daily)? ☐ Very regular ☐ Somewhat regular ☐ Not very regular ☐ Very irregular
2. Do you go to bed early (by 10:00-10:30 pm)? ☐ Yes ☐ No
3. Do you get up early (by 6:00-6:30 am)? ☐ Yes ☐ No
4. Do you eat your meals on time? ☐ Yes ☐ No
5. How often do you exercise? ☐ Regularly ☐ Occasionally ☐ Never
6. What type of exercise do you do, if any? _____
7. Is your exercise? ☐ Vigorous ☐ Moderate ☐ Light ☐ None
8. Do you practice meditation? ☐ Yes ☐ No
   a. How often? ☐ Regularly ☐ Occasionally ☐ Never
   b. What kind? _____
9. Do you take daytime naps? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
10. Do you travel a lot? ☐ Yes ☐ No
11. How often do you:
    a. Smoke: _____
    b. Drink alcohol: _____
    c. Drink caffeinated beverages: _____
12. Do you feel you take enough time for yourself? ☐ Yes ☐ No
13. How many hours per day do you use a computer? _____
14. How many minutes per day on a cell phone? _____
15. Are you having work or family problems that are impacting your health? ☐ Yes ☐ No
16. Do you perform "cleansings'? ☐ Yes ☐ No
    Describe: _____

ENVIRONMENT:

1. What direction does your house face? (N/NE/E/SE/S/SW/W/NW) _____
2. What side of the house do you enter? (N/NE/E/SE/S/SW/W/NW) _____
3. What direction does your head of your bed point towards? (N/NE/E/SE/S/SW/W/NW) _____
4. Do you live near a power plant or high tension wires? ☐ Yes ☐ No
5. Are you exposed to chemicals, pesticides or other toxins on a regular basis? ☐ Yes ☐ No
6. Have you recently painted or renovated your home or office? ☐ Yes ☐ No

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SECTION FOR WOMEN:

Menstrual History:

Age of onset: _____

Date of last period: _____

Date of last GYN exam: _____ Any abnormalities? ☐ Yes ☐ No

(If yes, describe) _____

Do you take birth control pills? ☐ Yes ☐ No

Length of time taking: _____

1. Which of the following describes your menstruation? (Choose as many as apply)
   ☐ Regular ☐ Absent ☐ Irregular ☐ Too frequent ☐ Infrequent ☐ Menopause

(If you are post-menopause, please skip to Question 5)

2. How many days does your menstrual period last?
   ☐ Zero to four days ☐ Five to seven days ☐ More than seven days ☐ Spotty/irregular

3. Is your menstrual flow? ☐ Heavy ☐ Light ☐ Normal

4. Associated symptoms (before or during Menstruation):
   ☐ None ☐ Fluid retention ☐ Pain ☐ Acne
   ☐ Other _____

5. Do you have any discharge outside of your menstrual period? ☐ Yes ☐ No

6. Do you have any itching of vaginal area? ☐ Yes ☐ No

7. Pregnancies:
   a. Are you pregnant now? ☐ Yes ☐ No ☐ Don't know
   b. Number of children: _____
   c. Number of pregnancies: _____
   d. Describe any complications with pregnancy:
      _____

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AYURVEDA QUESTIONNAIRE

What is Your Body Type (Dosha)?

PLEASE ASSIGN A RELATIVE SCORE UNDER THE APPROPRIATE DOSHA

Instructions: *For each item, circle the number that indicates how well the statement describes you. Circle "0" if it does not describe you at all. Circle "6" if it describes you fully. If it describes you somewhat, circle a number between "0" and "6" to show how much it describes you.* ***Total all*** *the numbers for each section and transfer the scores for Vata, Pitta, Kapha to the history form. This gives you an opportunity to think about the doshas in a personal way --- the scores may or may not reflect your actual prakriti.*

Section 1 --- VATA

1. Quick about doing things, walks quickly	0	1	2	3	4	5	6
2. Poor memory	0	1	2	3	4	5	6
3. Enthusiastic and vivacious	0	1	2	3	4	5	6
4. Thin physique, don't gain weight easily	0	1	2	3	4	5	6
5. Learn new things very quickly	0	1	2	3	4	5	6
6. Veins quite visible	0	1	2	3	4	5	6
7. Have difficulty making decisions	0	1	2	3	4	5	6
8. Digestion not too strong, tendency to have gas or constipation	0	1	2	3	4	5	6
9. Cold hands and feet	0	1	2	3	4	5	6
10. Tendency towards anxiety and worry	0	1	2	3	4	5	6
11. Sensitive to cold weather	0	1	2	3	4	5	6
12. Easily influenced by environment	0	1	2	3	4	5	6
13. Talkative, rapid in speech	0	1	2	3	4	5	6
14. Joints make cracking and popping sounds	0	1	2	3	4	5	6
15. Not much tolerance for physical exercise or work	0	1	2	3	4	5	6
16. Teeth are either very large or very small and somewhat irregularly spaced or cooked	0	1	2	3	4	5	6
17. Emotional	0	1	2	3	4	5	6
18. Difficulty in falling asleep or light and interrupted sleep	0	1	2	3	4	5	6
19. Dry skin	0	1	2	3	4	5	6
20. Dreams frequently involve fear, anxiety, being chased, running, jumping, flying, falling	0	1	2	3	4	5	6
21. Easily become afraid	0	1	2	3	4	5	6
22. Like to travel	0	1	2	3	4	5	6
23. Lean body type	0	1	2	3	4	5	6
TOTAL VATA SCORE: _____							

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Section 2 --- PITTA

1. Very sharp intellect	0	1	2	3	4	5	6
2. Strong digestion--can eat anything you like	0	1	2	3	4	5	6
3. Perspire easily	0	1	2	3	4	5	6
4. Aversion to hot weather—prefer weather that is too cold rather than too hot	0	1	2	3	4	5	6
5. Become uncomfortable if a meal is delayed or missed	0	1	2	3	4	5	6
6. Become irritable or angry easily	0	1	2	3	4	5	6
7. Very orderly and precise in your activities	0	1	2	3	4	5	6
8. Presence of any of these: early graying hair, balding, sandy blond or red hair color, early wrinkling	0	1	2	3	4	5	6
9. Large capacity for food	0	1	2	3	4	5	6
10. Stubborn, stick to your own ideas	0	1	2	3	4	5	6
11. Outspoken in your ideas	0	1	2	3	4	5	6
12. Bold and adventurous	0	1	2	3	4	5	6
13. Chivalrous and courteous	0	1	2	3	4	5	6
14. Complexion which is red or yellowish in color	0	1	2	3	4	5	6
15. Two or more bowel movement per day which tend to be somewhat loose	0	1	2	3	4	5	6
16. Prefer cold foods and drinks	0	1	2	3	4	5	6
17. Sharp or abrupt in speech	0	1	2	3	4	5	6
18. Anger comes easily but is short lived	0	1	2	3	4	5	6
19. Sharp, intelligent or penetrating eyes	0	1	2	3	4	5	6
20. Impatient	0	1	2	3	4	5	6
21. Sensitive to the sun—prefer the shade	0	1	2	3	4	5	6
22. Perfectionist	0	1	2	3	4	5	6
23. Medium body build and weight	0	1	2	3	4	5	6
TOTAL PITTA SCORE: _____							

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AYURVEDA QUESTIONNAIRE

Section 2 --- KAPHA

1. Tend to be slow and easy about doing things	0	1	2	3	4	5	6
2. Larger body build, strong muscles	0	1	2	3	4	5	6
3. Tend to gain weight easily	0	1	2	3	4	5	6
4. Easily able to miss a meal without discomfort	0	1	2	3	4	5	6
5. Peaceful mind, not easily disturbed	0	1	2	3	4	5	6
6. Tendency toward excess mucous, phlegm, respiratory problems, allergies, or sinus problems	0	1	2	3	4	5	6
7. Thick, dark, healthy, wavy hair	0	1	2	3	4	5	6
8. Happy appearance	0	1	2	3	4	5	6
9. Sleep deeply—need 8 hours or more	0	1	2	3	4	5	6
10. Soft, smooth skin	0	1	2	3	4	5	6
11. Strong, white, regular teeth	0	1	2	3	4	5	6
12. High tolerance for physical work or exercise	0	1	2	3	4	5	6
13. Slow eater	0	1	2	3	4	5	6
14. Soft, pleasing, attractive appearance	0	1	2	3	4	5	6
15. Slow, stable gait when walking	0	1	2	3	4	5	6
16. Speech tends to be sweet and soft in nature	0	1	2	3	4	5	6
17. Slow to get irritated	0	1	2	3	4	5	6
18. Excellent memory	0	1	2	3	4	5	6
19. Tendency towards plumpness	0	1	2	3	4	5	6
20. Athletic physique	0	1	2	3	4	5	6
21. Long, thick eyelashes	0	1	2	3	4	5	6
22. Large, soft, melting eyes	0	1	2	3	4	5	6
TOTAL KAPHA SCORE: _____							

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DIGESTION ASSESSMENT BY DOSHA PREDOMINANCE

E.G. IF A RELATIVE SCORE IS 5 AND THE QUESTION PERTAINS TO VATA ASSIGN 5 TO VATA, BUT IF YOU FEEL A QUESTION PERTAINS TO VATA AND KAPHA THE ASSIGN 2.5 TO EACH AS LONG AS RELATIVE SCORE OUT OF 5

QUESTION	RELATIVE SCORE	VATA	V	PITTA	P	KAPHA	K
Is your hunger	1	Irregular, varies from meal to meal		Generally strong; cannot skip meals		Mild; can generally easily skip meals	
After eating, speed of digestion (times it takes to feel hungry again) is	1	Irregular, varies from meal to meal		Quick; I feel hungry again after only a couple of hours		Slow; I'm not hungry again for 5-6 hours	
Food capacity (amount you can eat at time)	1	Varies from meal to meal		Large as compared to most other people		Small as compared to most other people	
Fluctuations of body weight	1	Easy to lose, difficult to gain; I tend to be underweight		Can maintain normal weight even with fairly large food intake		I gain weight easily, even with moderate food intake. Difficult to lose weight	
Energy level	1	Variable or low compared to others		Abundant compared to others		Good, but may tend toward laziness	
Regularity of bowel movements	1	Irregular, tending toward constipation		Frequent; often more than 1-2 times a day		Regular, once or twice daily	
Quality of stool	1	Hard, dry		Loose		Well-formed	
Add 1 point for each of the symptoms listed	1	a. Gas or bloating b. Frequent belching c. Constipation d. Intestinal cramping or discomfort		a. Acid stomach b. Reflux/heartburn c. Diarrhea tendency		a. Sluggish digestion (regularly, not variable) b. Heaviness or sleepy after eating (often) c. Stool sticky or with mucus	
Totals for V-P-K							

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AYURVEDA QUESTIONNAIRE

BRIEF VIKRITI ASSESSMENT BY DOSHA PREDOMINANCE

BASE YOUR CHOICES CONSIDERING HOW YOU HAVE BEEN FEELING RECENTLY, IN THE LAST MONTH OR TWO

FEATURE	RELATIVE SCORE	VATA	V	PITTA	P	KAPHA	K
Face/Complexion	5	Oval or thin, pale or grayish complexion		Reddish or ruddy complexion, early wrinkling		Fair, clear, "glowing' complexion	
Psychomotor movements/Gait/ Speech	5	Quick, always moving		Purposeful, sharp, precise, stable		Methodical, relaxed, slow, stable	
Body weight	7.5	Light		Medium		Heavy	
Body frame	7.5	Small-bone, bony, angular, less muscular		Medium frame and musculature		Large frame, sturdy, plump, good/large musculature	
Joints	5	Prominent bony protuberances		Medium		Rounded, well-covered	
Eyes, size and shape	2.5	Small, deep-set or protuberant		Medium size, sharp or penetrating appearance		Large	
Tendons and Veins	5	Prominent, very visible		Medium prominence and visibility		Well-covered, hidden	
Abdominal wall thickness	5	Thin		Medium		Thick (increased adipose tissue)	
Skin quality	5	Tends toward dryness		Fair, burns easily		Tends toward oiliness	
Temperature intolerance	2.5	Cold temperature		Hot temperature		Cool and damp, or comfortable at most temperatures	
Typical emotional reaction to challenges	2.5	Worry, anxiety		Anger, irritability		Generally remains stable, calm	
Physical strength and stamina	2.5	Variable or low compared to others		Medium to strong compared to others		High compared to others	
Type of digestion: From Digestion Assessment form	Insert V-P-K score						
Types for V-P-K							

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AMA QUESTIONNAIRE

PLEASE MARK TO WHAT DEGREE OF AMA (IMBALANCE) IS BUILDUP IN YOUR BODY APPLY TO YOU (1=0% AND 5=100%)

	0%	25%	50%	75%	100%
1. I tend to feel obstruction/blockages in the body. *(Constipation, congestion/heaviness is the head area, blocked nose, general feeling of non-clarity, or other)*	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. When I wake up in the morning, I do not feel clear; it takes me quite some times to feel really awake.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. I tend to feel tired or exhausted mentally and physically.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. I get common colds or similar ailments several times a year.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. I tend to feel heaviness in the body.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. I tend to feel that something is not functioning properly in the body. *(breathing, digestion, elimination, or other)*	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. I tend to be lazy, e.g., the capacity to work is there, but there is no inclination.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8. I often suffer from indigestion.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9. I tend to have to spit repeatedly.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
10. Often I have no taste for food and no real appetite.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
11. My tongue is often coated especially in the morning.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

ANY ADDITIONAL INFORMATION: