Optimal WELLNESS

CONFIDENTIAL CLIENT HISTORY

Client's Name:_____

Client's Address:_____

City, State, Zip:_____

Telephone: Home:_____ Work:_____

E-mail:_____

Birth date:_____

Marital/partner status:_____

# of children: _____Ages:_____

Occupation: _____

How did you hear about Samadhi Ayurveda? :

_____

FINANCIAL POLICY AGREEMENT

1. The Center does not bill insurance companies for services.
2. Panchakarma (Ayurvedic bodywork and cleansing techniques) services may be recommended and provided at the Center.
3. Payment of $150 for initial and follow up consultation is expected in full at time of appointment.

I have read and understood the financial policies of Optimal Wellness AZ.
Client's Signature:

_____Date:_____

1. Intention of Program: To educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. As you begin to move towards balance, you become more conscious and your natural, innate intelligence wakes-up, you begin to naturally make choices that are nurturing, healing, and balancing. You may be educated and empowered to take charge of your own health, and begin to develop the awareness to bring balance and health to each moment of your life, restoring you to your true joyful nature and present to the beauty and magic of life.

2. Outline of Services: 90 minute Consultation; an opportunity to assess your current physical, mental and spiritual routines, your prakruti (fundamental state of balance) and your vikruti (current imbalance). I will begin to educate you on your individual constitution and the basics of Ayurveda. You will be introduced to new practices as part of your plan for achieving balance. Practices may include meditation, yoga, dietary adjustments, herbs, breathing exercises and other Ayurvedic therapies all designed to further your education, awareness and ability to bring balance to your life. Periodic 60 min. follow-up sessions will be recommended to monitor and support your progress. In this way you can integrate lifestyle changes over time and we can make any adjustments needed in your program.

3. Ayurveda is not about instantaneous results, although you may see many immediate benefits. In accordance with the laws of nature, it will take time to gently restore full balance. Life is dynamic and we are part of life. We continually need to modify our lifestyle to the changing seasons, emotions, stresses etc. to achieve balance. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living. Using the ancient wisdom of Ayurveda I will educate, empower and support you as a dynamic individual, but it is up to you to bring this into your daily life. It is a simple, natural science that takes time, as it takes time for the stream to wear the stone smooth, but gently, over time it changes form completely. It is amazing the difference a small adjustment in your diet or lifestyle can make to create greater well-being. I am excited and honored to assist you in discovering your uniqueness and create a balanced life with radiant health and a peaceful mind.

Client Signature: _____

Ayurvedic Practitioner: _____

Optimal Wellness AZ, Sharmane Solomon NP, Certified Ayurvedic Educator/ Practitioner

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Please take quiet time and space to answer these questions. Take this as an opportunity to bring awareness to areas of your life that may need more attention. If a question does not apply or you do not know the answer, that is OK.

1. What are you currently doing in your life that brings you peace, health, balance and/or nurtures your soul?

2 What is your intention for this Ayurvedic Lifestyle Consultation?

a)

b)

c)

2. Where in your health, life, and relationships (to self and others) do you experience a lack of freedom, balance, and joy?

3. Which areas in your life are you most interested in bringing balance to?

4. If you achieved a perfect state of health, which is balance between your inherent energies, or "doshas" and your body, mind and spirit, what would your life look like? How would you feel? What would you be doing? What would be different? Paint a picture for yourself. Use the back if necessary.

5. What results do you want to produce in your physical body?

6. What results do you want to produce in regards to your mental and emotional well-being?

7. Circle all that apply: under stress, do you find yourself anxious, stressed, depressed, or easily brought to annoyance or anger?

8. How can I best support you in achieving the health, vitality, and balance you want in your life?

9. Do you know what you would have to give up to have the results you want?

10. What do you want your spiritual life to look like?

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CHIEF HEALTH CONCERNS

What are your main health concerns at this time? Order by importance to client.

Primary Concerns	**Clinician Notes**
1.	
2.	
3.	
4.	
5.	
6.	

PAST MEDICAL HISTORY

Include major conditions, dates of treatment and procedures performed:

1. Serious illnesses:_____

_____

2. Hospitalizations:_____

3. Operations:_____

4. List other pertinent past conditions:_____

5. Have you been under the care of a licensed health care professional in the past year?
☐Yes ☐No

If so, for what reasons;_____

_____

6. Is there any possibility that you are pregnant? ☐Yes ☐No

FAMILY HISTORY

Please check the appropriate boxes and indicate family members relationship to you.

☐ Cancer	☐ Diabetes
☐ High Blood Pressure	☐ Heart Disease
☐ Stroke	☐ Mental Disorder
☐ Other (explain)	☐ Other (explain)

CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, supplements are you currently taking?
Please include significant remedies that you have recently stopped taking.

Name of substance:_____
☐*Prescription* ☐*over-the-counter* ☐*herbal* ☐*vitamin* ☐*other*

Who recommended/prescribed it?_____

Purpose of substance:_____

How long have you been taking it:_____

In what form do you take it (include dosage):_____

How often do you take it?_____

What effects have you noticed?_____

Name of substance:_____
Prescription *over-the-counter* *herbal* *vitamin* *other*

Who recommended/prescribed it?_____

Purpose of substance:_____

How long have you been taking it:_____

In what form do you take it (include dosage):_____

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Who recommended/prescribed it?_____

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How long have you been taking it:_____

In what form do you take it (include dosage):_____

How often do you take it?_____

What effects have you noticed?_____

Name of substance:_____
Prescription *over-the-counter* *herbal* *vitamin* *other*

Who recommended/prescribed it?_____

Purpose of substance:_____

How long have you been taking it:_____

In what form do you take it (include dosage):_____

How often do you take it?_____

What effects have you noticed?_____

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DAILY ROUTINES

To be filled out by client

DAILY SCHEDULE ***(include approximate times)***
1. *Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities).*

Time	Activities	Variations
Morning		
Awaken		
Breakfast		
Activities		
Mid-day		
Lunch		
Activities		
Evening		
Supper		
Activities		
Night		
Activities		
Bed time		

2. *List regular practices that are not included in the above schedule, e.g., exercise, meditation, spiritual practices, etc.*

3. *Other comments about daily routines:*

4. *What types of food(s) are eaten on a regular basis?*

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

6. *Are there any routines around eating:*

7. *Any current or past problems with chronic eating disorders or other food related issues?*

☐***Yes*** ☐***No***

ALLERGIES OR SENSITIVITIES

8. *Do you have allergic reactions to any substances? If yes, please list.*

GENERAL HEALTH HABITS

9. *How many cups of caffeinated beverages do you drink per day?*

 # _____ Type(s) of beverage: coffee/tea/soda

10. *How many cups of non-caffeinated beverages do you drink per day?*

Type(s) of beverage: herbal tea/milk/juice/other

11. *How much water do you drink per day?_____*

12. *Do you exercise regularly?* ☐*Yes* ☐*No*
Length of time: _____

Times per week: _____

Type(s) of exercise:

13. *If you smoke, how many cigarettes do you smoke per day?* _____

Have you ever smoked? ☐*Yes* *No* ☐ *Amount/day:* _____ *When quit?*

_____

14. *If you drink alcohol, how many glasses of alcohol per week?* (Include beer, wine, liqueurs and hard liquor) # _____*per week Type(s) of beverage:*_____

15. *Any current or past problems with addiction or substance abuse?* ☐*Yes* ☐*No*

Substance: _____ *Amount:* _____

When quit? _____

16. *Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite, bloating, gassy,ect):*

17. *Body temperature: Do you generally run warm or cold? Please explain:*

18. Please describe your current sleep patterns.

19. Are your current sleep patterns different from your typical sleep? How?

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REVIEW OF SYMPTOMS

Check all symptoms that are of concern to you at this time that you want to discuss with the practitioner. Please indicate any area in which you have experienced a severe episode and indicate if episode was in previous 6 months or prior to 6 months time.

Head:		**Eyes:**		**Digestion:**	
Headaches		Soreness		Burning Indigestion	
Dizziness		Redness		Belching	
Fainting Spells		Burning		Cramping/Pain	
Loss of Balance		Mucous		Regurgitation	
Difficulty Thinking Clearly		Dryness		Vomiting	
Difficulty Remembering		Itching		Excessive Gas	
Thinning or Loss of Hair		Twitching		Bloated after meal	
		Blurred/Loss of vision		Constipation <1 BM/ Day	
Mouth:				Diarrhea	
Excessive Thirst		**Chest:**		Bloody Stool	
Loss of Taste		Pain in chest		Alternating Constipation and Diarrhea	
Strange Taste		Tightness/Pressure			
Lip Ulcers or Legions		Heart Palpitations		**Circulation:**	
Bad Breath		Shortness of Breath		Varicose Veins	
Dry Cracking Lips		Difficulty Breathing		Cold Hands and Feet	
Tongue Pain		Persistent Cough		Swollen Ankles	
Bleeding Gums		Frequent Chest Colds		Calf Pain	
Receding Gums				Swollen Eyes	
Tooth Pain		**Nose:**			
TMJ		Loss of Smell		**Urinary:**	
		Pain		Loss of Control	
Ears:		Bleeding		Painful Urination	
Hearing Loss		Discharge		Retention/Dribbling	
Ringing		Post nasal drip		Often During Day	
Earaches		Sinus Congestion		Often During Night	
Discharges				Blood in Urine	
Bleeding		**Skin:**		Pain in Kidney	
		Dry/Flakey		Bladder Infection	
Neck:		Rashes			
Pain		Blisters			
Swollen Glands		Acne			
Lumps		Changing/Bleeding Moles			
Stiffness		Insect Bites			

Muscles & Joints:		**Nerves:**		**Female Reproductive:**	
Swollen Joints		Loss of Taste, Smell or Touch		Irregular Cycle	
Pain/Ache in Joints		Tingling Sensations		Heavy/Prolonged Bleeding	
Persistent Muscle/ Bone Pains		Tremors in Limbs		Missed Menses	
Tremors in Muscles		Uncoordinated Muscles/limbs		Painful Menses	
Atrophy/Muscle Weakness				Spotting	
		Male Reproductive:		Discharge	
Breast:		Prostate Gland Swollen/ Painful		PMS Symptoms	
Swelling		Low Sperm Count		Pregnant	
Redness		Low Motility		Miscarriage	
Lumps		Genital Sores or Lesions		Infertility	
Nipple Discharge		Genital Discharge		Genital Sores	
Tenderness/Pain				Ovarian Cyst	
				Fibroids	

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Waiver and Release Memorandum

This form acknowledges that I have signed up for a consultation with Optimal Wellness AZ.
I acknowledge that this consultation does not undertake to diagnose or prescribe for any disease, illness, or injury. No medical treatment will be offered or given. I understand that the ayurvedic practitioner/consultant reserves the right to discontinue a registrant's privileges at his sole discretion. In such cases, the consultation fee that has been paid in full or in part will be refunded. No other expenses that may have been incurred in this context, such as transportation, accommodation, etc. are subject to reimbursement. The educational material of the consultation may include recommendations and/or guidelines for diet and lifestyle changes and specific herbal formulations. These guidelines are considered intrinsic to the Ayurvedic body of knowledge and are not meant to be used to treat, cure, or diagnose any identified illness or disease.
I HAVE READ and I understand the foregoing memorandum, which outlines the scope of the consultation I have signed up for. I specifically understand that the consultation is NOT offered by a licensed medical doctor or physician, and that it will not cover the discussion of medical treatments of any kind. Neither the information nor the products recommended (when any) are intended to treat, mitigate, cure, or prevent any disease. All information provided will be for the sole purpose of imparting education on Ayurveda and the Ayurvedic protocol for wellness.
I acknowledge receipt of this memorandum. I hereby release, indemnify, save and hold harmless Optimal Wellness AZ, LLC its' consultants, company, its owners, directors, officers, employees, agents, assignees, subsidiaries, and licensees, from and against any costs, fees, expenses, liabilities, or claims arising from any activity, treatment or therapy with Samadhi Ayurveda or from any conduct or activity arising from activities involving myself or any conduct or activity
involving any of Optimal Wellness AZ's product line, including but not limited to illness, injury, death, theft, or other liability, regardless of any act or omission from Optimal Wellness AZ or his invitees or licensees. As a material part of the considerations to participate in such activities with Optimal Wellness AZ, I hereby assume all risks of injury to persons or damage to property arising from any cause, and I hereby waive all claims against Optimal Wellness AZ or their invitees or licensees. I am assuming the risk of all known and unknown claims I may have. In this regard, I waive the benefits of any state or federal or international statute that may allow protection against unknown or unanticipated claims, damages, liabilities, or actions, whether contractual, statutory, or tortuous in nature. Optimal Wellness AZ is furthermore not liable for any injury, death, theft, damage, accident, delay or inconvenience in the event that I am damaged or injured regardless of the cause.
By signing this memorandum, I intend it to be a complete and unconditional RELEASE of all liability to the greatest extent allowed by law. If I, or anyone else on my behalf, makes claim against Optimal Wellness AZ's Center or the consultant, I or my estate will INDEMNIFY, SAVE, and HOLD them HARMLESS from any litigation, expense, attorney fees, loss, liability, damage or cost which may occur as a result of such claim to the fullest extent permitted by law. I agree that if any portion of this memorandum is held to be invalid, the balance shall continue in full force and effect.

NAME: _____ SIGNATURE: _____

DATE: _____