Beayurvedic Wellness Center

23023 Orchard Lake rd. Bldg. G Farmington MI 48331. Phone- 248-631-7271.

Audio and Video recording is strictly prohibited.

Name: _____

Address: _____

City, State, Zip: _____

Date: _____/_____/_____ Date of Birth_____/_____/_____Gender: Male/Female/other

Home Phone_____ Cell_____

Email_____

Age: _____Occupation_____

Marital status_____ No. of Children_____Ages_____

Physician_____

Phone _____

In case of emergency: Contact Name_____

Relationship:

_____Phone_____

Please take a moment to carefully read the following information and circle where applicable:

1. How did you hear about us - Friend/ Internet/ workshop/ other
2. Have you ever had an Ayurvedic consultation or therapy before? Y N
3. Do you have an exercise routine? Y N
4. Do you Smoke or Drink? Y N
   If Yes, how many times a week?
5. Any current or past use of addictive substance? Y N If Quit When_____
6. Are you allergic to any Food, Drugs or other substances? Y N

Please specify_____

7. Is your work Sedentary Type Travelling?_____

8. Are you taking any medications? List them below:

_____

_____

_____

9. Are you taking any herbal supplements or vitamins? List them below

_____

10. Do you frequently suffer from stress? 1- minimal, 2-4 manageable, 5 - High

11. Are you sexually active Y N

12. Do you follow any type of spiritual practice?

13. Any Past history of Major illness_____

Surgeries	Trauma
Mental imbalance	Major stress
Weight issues	Serious injuries
Vision problems	Tinnitus

14. Have you been to your regular physical under care of a licensed health care practitioner? If so when was the last visit _____

15. Family History of any major illness: _____

_____

Do you have history of any conditions mentioned below:

		Yes	No
1.	Asthma	( )	( )
2.	Arthritis	( )	( )
3.	Anemia	( )	( )
4.	Blood Pressure	( )	( )
5.	Back pain	( )	( )
6.	Bleeding disorder	( )	( )
7.	Chronic constipation	( )	( )
8.	Chronic Diarrhea	( )	( )
9.	Chronic headaches	( )	( )
10.	Contagious diseases	( )	( )
11.	Chemotherapy	( )	( )
12.	Chest pain	( )	( )
13.	Cholesterol (elevated)	( )	( )
14.	Diabetes	( )	( )

15. Dental complications	( )	( )
16. Epilepsy/ Seizures	( )	( )
17. Fainting	( )	( )
18. Glaucoma	( )	( )
19. Heart disease	( )	( )
20. Hemorrhoids	( )	( )
21. Implants/ Prosthesis	( )	( )
22. Hepatitis	( )	( )
23. HIV exposure	( )	( )
24. Kidney or bladder diseases	( )	( )
25. Mental health	( )	( )
26. Jaundice	( )	( )
27. Sinusitis	( )	( )
28. Shortness of breath	( )	( )
29. Stroke	( )	( )
30. Skin Conditions(eczema)	( )	( )
31. Thyroid	( )	( )
32. Ulcers, intestinal bleeding	( )	( )
33. Worms	( )	( )
34. Veneral disease	( )	( )

For Women only

Are you Pregnant?

If Yes- how many weeks? _____

What was your last day of Menstrual cycle? _____

Your period is/ was Heavy moderate light_____

Cycle __ 28 days __ 30 days __ 32 and above

Are you taking any hormone replacement therapy? Y/ N

No Audio or Visual recordings are permitted during the session.

1.Ayurveda is the traditional healing system from India, and is based on the idea that each person's path towards optimal health is unique. Your program is based on an understanding your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, yoga and meditation, Ayurvedic therapies, aromatherapy and therapeutic massages. The goal of all programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.

2.Beayurvedic center is not a Medical facility. Employees at Beayurvedic center are not trained in western diagnosis or treatment, no one in association with Beayurvedic LLC may recommend altering your prescriptions without the approval of your medical doctor. Your Practitioner may suggest that you speak to your doctor about reducing medications when he/she feels that it is appropriate.

2.Beayurvedic Center adheres to a strict professional code of ethical conduct in the handling of your personal information.

Beayurvedic Center is committed to ensuring the privacy of all information you provide. All information you share with us is

kept strictly confidential.

3.The material provided by Beayurvedic Center is for educational purposes only and any recommendations are not intended to replace the advice of your physician. You are encouraged to seek advice from a competent medical professional regarding the applicability of any recommendations with regard to your symptoms or condition. Beayurvedic Center makes no guarantee or warranty, express or implied, with respect to any products or services sold, including any warranty of merchantability or fitness for a particular purpose.

4.I agree to release, indemnify, and hold harmless Beayurvedic Center and its staff and volunteers ("The Indemnified Parties") from all claims for damages or injunctive relief resulting from the undersigned's participation in the events referred to as General and Therapeutic Yoga, General and Therapeutic Massage, Naturopathy, Ayurveda consultations and therapies, Panchakarma and Aromatherapy, including claims alleging that injuries or damages were caused by the negligence of any of the Indemnified Parties or of the undersigned.

6.The therapies that you are about to engage or remedies that you are about to ingest have been thoroughly explained to me. I have also had ample opportunity to ask questions about said therapies and remedies and the opportunity to have those questions answered.

7.I understand that the Ayurvedic therapy I receive is for balancing the Doshas and detoxifying the body. If I experience any pain or discomfort during the session, I will immediately inform the practitioner. I further understand that Ayurvedic therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician for any mental or physical aliment of which I am aware. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated to any changes in my medical profile and understand that there shall be no liability to the practitioner’s part should I fail to do so.

8.I also understand that any illicit or sexually suggestive remarks or advices made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment. The procedures you are about to engage or remedies that you are about to ingest have been thoroughly explained to me. I have also had ample opportunity to ask questions about said procedure and remedies and the opportunity to have those questions answered.

Client Signature _____

Date_____/_____/_____Witness_____

Consent to therapy of minor By my signature below, I hereby authorize Beena Vesikar to carry the therapy to my child or dependent as they deem necessary.

Sign of Parent /Guardian _____Date_____/_____/_____