Client Registration Form:

Name: | **Date:**
Address: | **Cellular Phone:**
Does this phone accept text messages?: Yes No
Email Address:

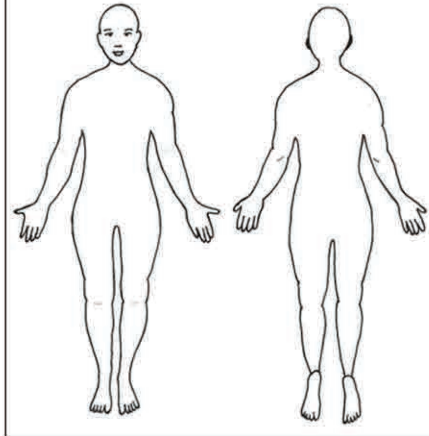
How did you first hear about Sound Shore Ayurveda?

Age: **Date of Birth:** **Place of Birth:**

Gender: Male Female Transgender/Other **Height:** **Weight:**

Occupation: **Are You Pregnant?:** Yes No **If Yes, What Trimester?:**

Family Medical History:



Personal Medical History:

Current Symptoms:

How Long Have You Been Experiencing These Symptoms?:

Sleep:

Do Experience Difficulty Falling Asleep? Yes No

Do You Suffer From Sleep Continuity Disturbance? (Waking Throughout The Night) Yes No

Are You Alert Or Tired Upon Waking In The Morning? Alert Tired

Are You Tired Or Drowsy In The Daytime? Yes No

Habits:

Alcohol: Type And Amount________________________ **Smoking:** Type And Amount__________________

Salt Intake: Light Moderate Heavy
Fat Intake: Light Moderate Heavy
Caffeine Intake: Light Moderate Heavy

Are You Taking Any Herbal Supplements? Yes No If Yes, What Are You Taking?_________________

Are You Taking Any Herbal Supplements? Yes No If Yes, What Are You Taking?_________________

Describe Your Exercise Routine:

Are You Willing To Take Herbal Supplements If Recommended By The Ayurvedic Practitioner After The Consultation? Yes No

CANCELLATION POLICY: FULL PAYMENT IS DUE IF YOU CANCEL YOUR SESSION WITHIN 48 HOURS OF YOUR APPOINTMENT.

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