UTRECHT AYURVEDA

Client Registration Form:

Name:

Address:

Date:

Cellular Phone:

Does this phone accept text messages?: Yes No

Email Address:

How did you first hear about Utrecht Ayurveda?

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

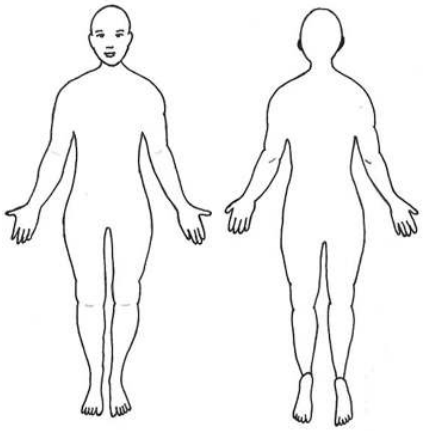
Gender: Male Female Transgender/Other **Height:** **Weight:**

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

Family Medical History:

Personal Medical History including any Surgeries:

Indicate with a circle where you are experiencing body pain.



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?**_____

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Describe Your Exercise Routine:

Name of Health Insurance provider?_____

Does your health insurance policy cover complementary Healthcare?: Yes No

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.