- Please provide your full name
- How old are you?
- Male/Female/Other/Prefer not to say
- **Contact Information**:
    - Phone: [Your primary phone number]
    - Email: [Your email address]
- What do you do for work?
- Who do you live with? (e.g., family, alone, roommates, pets)
    - Any other details about your living environment that might be relevant?
    - [Open-ended response]
- **What brings you to see us today?**
  Please describe your main health concern or reason for consulting with us. For example, are you experiencing any specific symptoms or looking to improve your overall wellness?
    - [Open-ended response]
- **When did this issue start?**
    - [Date or approximate time frame, e.g., a few weeks ago, last year]
- **How has it progressed over time?**
    - Has it gotten better, worse, or stayed the same? Please describe how it affects your daily life.
    - [Open-ended response]
- **How would you rate the intensity of your symptoms?**
    - [Mild/Moderate/Severe]
- **How often do you experience these symptoms?**
    - [Less than once a week/Several times a week/Daily/Most of the time]
- **Have you tried any treatments for this issue?**
    - If yes, what treatments (e.g., medications, therapies, lifestyle changes) and how did they work?
    - [Open-ended response]
- **Do you have any ongoing medical conditions?**
    - If yes, please list them (e.g., diabetes, hypertension, thyroid issues, PCOS).
    - [List conditions]
- **Are you currently taking any medications, supplements, or herbal remedies?**
    - If yes, please specify the name, dosage, and how long you've been taking them.
    - [List medications/supplements]
- **Have you had any surgeries, hospitalizations, or major infections in the past?**
    - If yes, please describe (include the date, condition, and treatment, e.g., appendectomy in 2018, malaria in 2020).
    - [Open-ended response]
- **Is there any family history of diseases that I should know about?**
    - For example, diabetes, heart disease, cancer, thyroid issues, or others in your parents, siblings, or grandparents.
    - [Open-ended response]
- **Please describe your typical daily routine.**
    - Include details about when you wake up, sleep, work, eat, and spend leisure time.[Open-ended response]

- **What is your diet like?**
    - Do you follow any specific dietary preferences or restrictions (e.g., vegetarian, vegan, gluten-free)?
    - What are your favorite foods or tastes (e.g., sweet, sour, salty, spicy, bitter, astringent)?
    - Do you have any food cravings or aversions?
    - [Open-ended response]
- **How often do you exercise, and what type of physical activity do you engage in?**
    - For example, walking, yoga, gym workouts, or none. How many hours per week?
    - [Open-ended response]
- **How do you manage stress?**
    - Do you practice meditation, yoga, or other relaxation techniques? How would you rate your stress level on a scale of 0-10 (0 = no stress, 10 = extreme stress)?
    - [Open-edged response]
- **How many hours do you sleep each night, and how is your sleep quality?**
    - Do you have trouble falling asleep, staying asleep, or feeling rested?
    - [Open-ended response]
- **Do you use any substances regularly?**
    - For example, alcohol, coffee, tea, tobacco, or others. If yes, how often and how much?
    - [Open-ended response]
- **How would you describe your digestion?**
    - Do you experience any issues like bloating, gas, constipation, diarrhea, or irregular bowel movements? How often do you have bowel movements?
    - [Open-ended response]
- **Do you feel hungry at regular times, or does it vary?**
    - For example, do you feel hungry at specific meal times, or is it unpredictable?
    - [Open-ended response]
- **How do you react to different weather conditions or seasons?**
    - For example, do you feel better in hot, cold, or humid weather? Do you notice any symptoms worsening in certain seasons?
    - [Open-ended response]
- **What are your taste preferences?**
    - Do you crave or avoid certain tastes (sweet, sour, salty, spicy, bitter, astringent)?
    - [Open-ended response]
- **Do you sweat easily, or not much at all?**
    - [Often/Not much/Rarely]
- **Have you ever consulted an Ayurvedic practitioner before?**
    - If yes, what treatments or advice did you receive, and how did they work for you?
    - [Open-ended response]
- **Are there any specific Ayurvedic practices you currently follow?**
    - For example, yoga, meditation, herbal teas, oil massages, or specific diets.
    - [Open-ended response]

- **In the last 3 months, have you experienced any of these symptoms?**
    - Please check all that apply and describe when they occur:
        - Poor appetite
        - Weight gain or loss
        - Fatigue or low energy
        - Poor sleep
        - Strong thirst (hot or cold drinks)
        - Night sweats
        - Fevers or chills
        - Cravings for specific foods
        - Other: [Please specify]
- **What do you hope to achieve with your health consultation today?**
    - For example, relief from a specific condition, better digestion, improved sleep, weight management, mental clarity, or overall wellness.
    - [Open-ended response]
- **Are there any specific areas of health you'd like to focus on?**
    - For example, skin health, mental well-being, fitness, or managing a chronic condition.
    - [Open-ended response]
- **Are there any other health concerns or questions you'd like to discuss?**
    - [Open-ended response]
- **What are your expectations from this consultation or treatment?**
    - For example, are you looking for immediate symptom relief, long-term lifestyle changes, or a combination?
    - [Open-ended response]