Copper Cup Ayurveda

Initial Consultation Form

Appointment date and time: _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone – Home: _____ Cell: _____ Work: _____

Email: _____

Birthdate: _____ Age: _____

Occupation: _____

Marital/Partner status: _____ # of children: _____ Ages: _____

Emergency contact name/number: _____

How did you hear about Copper Cup Ayurveda? _____

Why have you chosen to have an Ayurvedic consultation? _____

_____

What You Can Expect from Your Ayurvedic Consultation

Ayurveda is a natural healing system that has been successfully practiced for centuries. Originating in India, this medical tradition states that each person's path toward optimal health is unique – because each person is unique. The healing programs offered through Copper Cup Ayurveda are based on effective, time-honored principles that focus on understanding your particular body-mind constitution and the unique nature of your imbalance.

Your program may include lifestyle adjustments, dietary changes, herbal formulas, meditation, mantra, color/aroma/massage therapy, and other natural therapeutics. In order to successfully implement these Ayurvedic principles into your life, frequent regular follow-up visits are recommended over a 6-12 month period. The goal of all Ayurvedic 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.

Patient's Signature: _____ Date: _____

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Lisa Bracken
Clinical Ayurvedic Specialist
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Informed Consent / Financial Agreement / Cancelation Policy

All patients who participate in Ayurvedic healthcare through Copper Cup Ayurveda should be advised of the following information:

- If you are under medical care, or the care of another healthcare provider, your work with us will complement the work being done by your other providers.

- Oklahoma is a health freedom state, allowing complementary and alternative medical practitioners to practice without a license under specified conditions. The Health Freedom Law was passed in 1994 distinguishing allopathic medicine from homeopathic care. While we may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, we are evaluating our findings from an Ayurvedic perspective only and not from a Western medical perspective.

- This examination does not take the place of a medical evaluation. If, as a result of our examination, any findings suggestive of a possible medical imbalance is found, you will be referred to a Medical Doctor for further evaluation.

- We will take photographs of your face, hands, tongue, and body (with clothes). These photos are used to monitor progress. Please note that these photos will never be used or published in any public format.

- Your customized program often incorporates standardized herbal formulas available for purchase either directly through Copper Cup Ayurveda, ordered online, or custom-made through the California College of Ayurveda. These items are available at an additional charge.

- Payment in full is due at the time of the initial visit. We do not provide a monthly billing service, nor do we bill insurance companies for consultations or herbs. All patients will provide a credit card at the time of scheduling their first appointment. This card will be kept on file throughout the duration of their treatment with us.

- If you miss an appointment without giving 24 hours' notice, a $65 fee will be charged to the credit card on file.

I have read and understand all of the above information and give my permission to begin a program of health promotion with Lisa Bracken/Copper Cup Ayurveda.

Patient's Signature: _____ Date: _____

Confidential Patient History

Past Medical History

Please list any major condition(s) and dates of diagnosis, treatment, and procedures performed.

Are you under the care of a licensed healthcare professional or any other healthcare provider? ☐ Yes ☐ No

If so, for what reasons:

_____

_____

_____

_____

_____

Serious illnesses: _____

Hospitalizations: _____

Operations: _____

List other pertinent past or current conditions:

_____

_____

Have you had any cosmetic surgery or procedures performed? ☐ Yes ☐ No

If so, please list: _____

Family History

Indicate which members of your immediate family have had these conditions. Go back one generation. If adopted, answer according to family heritage, if known.

☐ Cancer _____

☐ Diabetes _____

☐ Heart Disease _____

☐ High Blood Pressure _____

☐ Mental Disorder _____

☐ Stroke _____

☐ Other _____

Alcohol, Tobacco, and Substance Use	Practitioner Notes
Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Several times weekly ☐ Seldom ☐ Several times monthly How many glasses? _____ I prefer: ☐ Beer ☐ Wine ☐ Sweet or hard liquor	
Have you ever smoked tobacco? ☐ Yes ☐ No If yes, how much per day? _____ Have you ever smoked marijuana? ☐ Yes ☐ No If yes, how much per day? _____ If you quit smoking, what year did you quit? _____	
Any current or past use of other addictive or habitual substances? ☐ Yes ☐ No (Note: This will be kept confidential.) Please list all substances (current or long-term past usage): _____	

Regular Practices

☐ Exercise/Hatha Yoga (specify) _____	☐ Never	☐ Occasional ☐ Daily	☐ Several times/week ☐ Several times/month
☐ Team Sports/Recreation (specify) _____	☐ Never	☐ Occasional ☐ Daily	☐ Several times/week ☐ Several times/month
☐ Travel (include commute if applicable) _____	☐ Never	☐ Occasional ☐ Daily	☐ Several times/week ☐ Several times/month
☐ Spiritual Practices (specify) _____	☐ Never	☐ Occasional ☐ Daily	☐ Several times/week ☐ Several times/month
☐ Meditation/Prayer/Pranayama (specify) _____	☐ Never	☐ Occasional ☐ Daily	☐ Several times/week ☐ Several times/month
☐ Other (include creative activities) _____	☐ Never	☐ Occasional ☐ Daily	☐ Several times/week ☐ Several times/month

Relationship

How nourished do you feel in your relationship? (1 being the least, 10 the most.)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How often do you engage in sexual activity (include sex with partner and masturbation):

☐ Daily ☐ Several times/week ☐ Several times/month ☐ Occasionally ☐ Never

Is your current sexual activity satisfactory? ☐ Yes ☐ No

Practitioner Notes: _____

Food Choices

Please list the types of foods you eat on a regular basis. Be as detailed as possible.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What percentage of your food is organic? _____

Daily Liquid Intake (Indicate number of 8-ounce cups per day)

☐ Caffeinated Coffee/Tea _____ ☐ Herbal Tea/Juice _____ ☐ Cow/Goat Milk _____

☐ Decaffeinated Coffee/Tea _____ ☐ Soda/Diet Soda _____ ☐ Grain/Nut/Soy Milk _____

☐ Plain Water _____

Habitual Eating Patterns

Describe any current or past eating patterns or any other food-related issues.

_____

Allergies or Sensitivities

Please list any allergic reactions to food, pollen, medications, or any other substances:

_____

_____

_____

_____

_____

Daily Routine

Please list your habitual activities from the time you wake up until you go to sleep. Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis. You can include approximate times.

Morning	Time	Habitual Activities	Practitioner Notes
Awaken			
Breakfast			
Activities			
Other			

Daytime	Time	Habitual Activities	Practitioner Notes
Lunch			
Activities			
Other			

Evening	Time	Habitual Activities	Practitioner Notes
Dinner			
Activities			
Bedtime			
Other			