re:sculpt

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910 Waukegan Road
Glenview, IL 60025

(p) 847.657.0881
(f) 847.657.0882

Ayurvedic Consultation Client Information:

Name: _____

Address _____

City _____ **State** _____ **Zip** _____

Phone: (PLEASE CHECK THE PREFERRED NUMBER FOR MESSAGES)

_____ _____ _____

❍ HOME ❍ WORK ❍ CELL

What's the earliest/latest we can phone your home?

_____

Email _____

Date of Birth: _____ **Gender Identity:** _____

Social Security Number: _____

Date of injury (If applicable): _____ **Date last worked:** _____

Emergency Contact:

Name: _____

Relation: _____

Phone Number: _____

Referring Physician or practitioner:

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone: _____ **Fax:** _____

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Client History

Please tell us about you:

Name: _____ **Age:** _____

Why have you chosen ayurveda?

_____

Please tell us about your activities at work and at home:

_____

_____

_____

_____

_____

Occupation _____

Is the majority of your day spent: ❍ SITTING ❍ STANDING ❍WALKING

What are your hobbies?_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

Client Medical History

Are you taking any medications? ❍ YES ❍ NO

If yes: what type and for what condition?

_____

Are you taking any supplements? If yes: what kind?

_____

_____

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Client Medical History (Continued)

Do you have a history of:

Seizures	❍ YES	❍ NO	**Dizziness**	❍ YES	❍ NO
Cancer	❍ YES	❍ NO	**Night Sweats**	❍ YES	❍ NO
Stroke	❍ YES	❍ NO	**Exposure/Treatment TB**	❍ YES	❍ NO
Falls	❍ YES	❍ NO	**Cough over 2 weeks**	❍ YES	❍ NO
Diabetes	❍ YES	❍ NO	**Fever over 2 weeks**	❍ YES	❍ NO
Unexplained weight loss	❍ YES	❍ NO			

Surgeries: If yes, please expand: types and years of surgeries

Cardiovascular:

High Blood Pressure	❍ YES	❍ NO	**Pace maker**	❍ YES	❍ NO
Heart Disease	❍ YES	❍ NO			

Bowel:

Gas:	❍ YES	❍ NO	**Constipation:**	❍ YES	❍ NO
Bloating:	❍ YES	❍ NO	**Food Allergies:**	❍ YES	❍ NO
Diarrhea:	❍ YES	❍ NO	**Blood in Stool:**		

Frequency of bowel movements:
What time of day do you usually eliminate?

Urogenital:

Urination Frequency: During day_____ **During Night** _____

Burning:	❍ YES	❍ NO	**Dribbling:**	❍ YES	❍ NO

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Client Medical History (Continued)

Women's Health:

Are you now or is there a chance that you may be pregnant? ❍ YES ❍ NO

Length of menstruation cycle: _____

Age at first period: _____ **Date of last period:** _____

Hot Flashes: ❍ YES ❍ NO **Night Sweats:** ❍ YES ❍ NO

Do you use birth control: ❍ YES ❍ NO **Pain with intercourse:** ❍ YES ❍ NO

Number of Pregnancies _____ **Number of full term:** _____

Type of Delivery: VAGINAL ❍ YES ❍ NO CESAREAN SECTION: ❍ YES ❍ NO

Episiotomy: ❍ YES ❍ NO

Complications:

_____

_____

Men's Health:

Pain with ejaculation ❍ YES ❍ NO **Pelvic pain** ❍ YES ❍ NO

Pain with intercourse ❍ YES ❍ NO

Endocrine System:

Average hours of sleep per night: _____

What time do you go to bed: _____

Is there any other information you think might be beneficial in sharing?

_____

_____

_____

_____

_____

_____
PATIENTS SIGNATURE

_____
DATE

_____
GUARDIAN SIGNATURE

_____
DATE

Reviewed with client: _____

_____
THERAPIST SIGNATURE

_____
DATE

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Ayurvedic acknowledgement and consent to receive services

Name of Patient: _____

Welcome to re:sculpt,llc. As you know, I am an ayurvedic practitioner. I am not a liscenced physician, nor are ayurvedic services licensed by the state. The goal of ayurveda is to maintain the health of the healthy and help restore balance to the dis-eased. As an ayurvedic wellness practitioner, I can educate you on your prakriti, which is where your balance of health lies, and make recommendations on diet, lifestyle and routine that will help maintain/regain your balance.

My training and education is from Kerala Ayruveda Academy. Classes focused on ayurveda philosophy and physiology, as well as the use of cooking, dinacharya (daily routine), yoga, and herbs to maintain health or return to health from an imbalanced state.

In order to use my services, I require that you acknowledge receipt of the information provided in this form and that you sign it. You will receive a copy. I will keep the original in my records for at least three years. Illinois has no laws regarding acknowledging forms. The state of California does have state law requirements. In an effort to better educate and serve my clients, I will follow the state of California requirements.

My method of treatment, ayurveda, is an alternative or complementary service to healing arts that are licensed by the state of California. Under section 2053.5 and 2053.6 of California's Business and Professions Code, I can offer you these services, subject to requirements and restrictions of that law. The purpose of this legislation intends, by enactment, to allow access by California residents to complementary and alternative health care pracitioners who are not providing services that require medical training and credentials. The Legislation further finds that these non medical complimentary and alternative services do not pose a known risk to the health and safety of California residents, and that restricting access to those services due to technical violations of the Medical Practice Act is not warranted. Again, please understand that to date, illinois has no laws or codes regarding ayurveda.

If you have any concerns about the nature of your treatment, please feel to discuss them with me. I recommend that you inform your medical doctor that you are receiving an ayurvedic consult.

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Acknowledgement and Consent to receive services:

I have read and understand the above disclosure about the ayurvedic treatment offered by the practitioner's training and education at re:sculpt. I have discussed with my pracitioner, _____, the nature of the services to be provided. I understand that my practitioner, _____, is not a licensed physician and that ayurvedic services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself with a medical doctor. I have consented to use the services offered by my practitioner, _____, and agree to be personally responsbile for the fees of re:sculpt, llc in connection with the services provided to me.

Signature: _____ Date: _____

Practitioner's Signature: _____ Date: _____

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Client Cancellation and Payment Policy

Re:sculpt, llc clients are seen by appointment only. Scheduling is based on a first come first served basis. To receive the full benefit of your session, please arrive on time.

Cancellation Policy

Cancelling An Appointment With No Charge: To cancel an appointment with no charge we require a twenty-four (24) hour notice. This notice must be given directly to re:sculpt, llc by calling 847-657-0881. Notice provided to your practitioner is not sufficient.

Cancellation Fee: If you call re:sculpt, llc directly and cancel your appointment within 24 hours of the scheduled appointment time, the cancellation will be 60% of the fee of service.

Full Price Required: If you do not call to cancel an appointment, you will be charged the full price of the session.

Payment Policy: Payment is due at time of service. Check or cash is accepted. Cancellations will be billed to the credit card of your choice.

_____

TYPE NUMBER EXP. DATE

By signing below, I agree to abide by the Cancellation and Payment Policies of re:sculpt, llc.

_____

CLIENT'S SIGNATURE

_____

DATE