re:fit, p.c.
910 Waukegan Road
Glenview, IL 60025

Please type in the fields below on your computer
Client signs pages 2, 3, 4

Name of Client: _____

Ayurvedic Consultation Client Information

Name _____ Age _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Preferred phone # ☐ Home _____ ☐ Work _____ ☐ Cell _____

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

Email _____ Gender identity _____ Pronoun pref _____

Date of Injury (if applicable) _____ Date Last Worked _____

Emergency contact

Name _____ Relation _____ Phone # _____

Referring physician or practitioner

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Client History

Why have you chosen Ayurveda?

Please tell us about your activities at work and at home

Occupation _____

How much of your day is spent Sitting _____ Standing _____ Walking _____

What are your hobbies?

What are your goals for treatment?

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Client Medical History

Name of Client: _____

Are you taking medications? ☐ yes ☐ no If yes, what type and for what condition?

Are you taking supplements? ☐ yes ☐ no If yes, what kind?

Do you have a history of:

seizures	☐ yes ☐ no	diabetes	☐ yes ☐ no	unexplained weight loss	☐ yes ☐ no
cancer	☐ yes ☐ no	dizziness	☐ yes ☐ no		
stroke	☐ yes ☐ no	night sweats	☐ yes ☐ no		
falls	☐ yes ☐ no	cough over 2 weeks	☐ yes ☐ no	exposure/ treatment TB	☐ yes ☐ no
		fever over 2 weeks	☐ yes ☐ no		

Surgeries: If yes, please explain type of each surgery and year performed

Cardiovascular

high blood pressure ☐ yes ☐ no
heart disease ☐ yes ☐ no
pace maker ☐ yes ☐ no

Urogenital

urination frequency during day _____ night _____
burning ☐ yes ☐ no
dribbling ☐ yes ☐ no

Women's Health

hot flashes ☐ yes ☐ no
night sweats ☐ yes ☐ no
do you use birth control? ☐ yes ☐ no
pain with intercourse ☐ yes ☐ no
vaginal delivery? ☐ yes ☐ no
cesarean section? ☐ yes ☐ no
episiotomy ☐ yes ☐ no
Are you now or is there a chance that you may be pregnant? ☐ yes ☐ no

menstruation cycle length _____
age at first period _____
date of last period _____
number of pregnancies _____
number of full term delivery complications _____

Bowel

gas	☐ yes ☐ no
bloating	☐ yes ☐ no
diarrhea	☐ yes ☐ no
constipation	☐ yes ☐ no
food allergies	☐ yes ☐ no
blood in stool	☐ yes ☐ no

frequency of bowel movements _____

time of day you usually eliminate _____

Endocrine System

average hours of sleep per night _____

what time do you go to bed? _____

do you sleep through the night? _____

how often do you wake up during the night? _____

Men's Health

pain with ejaculation	☐ yes ☐ no
pain with intercourse	☐ yes ☐ no
pelvic pain	☐ yes ☐ no

Other information to share? (use back if needed)

PATIENT SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE _____ DATE _____

THERAPIST SIGNATURE _____ DATE _____

re:fit, p.c.

Name of Client: _____

Ayurvedic Acknowledgement and Consent to Receive Services

Welcome to re:fit. As you know, I am an ayurvedic practitioner. I am not a licensed 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 diseased. 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. The training focused on ayurveda philosophy and physiology, as well as the use of daily routine, yoga, cooking and herbs to maintain health or return to health from an imbalanced state.

Please acknowledge receipt of the information provided in this form and sign at the end. I will keep the original in my records for at least three years. Illinois has no laws regarding Acknowledgement Forms, but 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.

The Ayurvedic method of treatment is an alternative or complementary service to healing arts that is licensed by the state of California. Under section 2053.5 and 2053.6 of California's Business and Professions Code, I can offer 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 complementary 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.

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

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:fit, p.c. I have discussed with my practitioner, _____, 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 responsible for the fees of re:fit, p.c. in connection with the services provided to me.

CLIENT SIGNATURE _____ DATE _____

PRACTITIONER SIGNATURE _____ DATE _____

re:fit, p.c.

Name of Client: _____

Client Cancellation and Payment Policy - Ayurveda

Re:fit 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. If you are going out of town or need to miss an appointment, please cancel any "standing appointments" as soon as possible.

- **Cancelling An Appointment With No Charge/ 24 Hours:** To cancel an appointment with no charge we require at least twenty-four (24) hour notice. This notice must be given directly to re:fit by calling 847-657-0881. *Notice provided to your practitioner is not sufficient.*
- **75% Cancellation Fee/ 6-24 Hours:** If you call re:fit directly and cancel your appointment between 6-24 hours of the scheduled time, there will be a 75% fee of the visit's charge.
- **Full Price Cancellation Fee/ 0-6 Hours or No Show:** If you cancel less than 6 hours before your scheduled visit, or 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. Cash, check, or credit card is accepted.

Collection Action:

I, the undersigned, understand and agree that if collection action should become necessary for recovery of any monies due under services rendered or products purchased, I am responsible for any and all collection costs, court costs, and attorney fees. I also understand and agree that accounts with balances outstanding more than thirty days from the date of service or purchase will be charged a service fee of 5% per month of the outstanding balance, until the balance is paid in full.

By signing below, I agree to abide by the Cancellation and Payment Policies of re:fit, p.c.

CLIENT SIGNATURE _____ DATE _____