Healthy life consultancy form

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____

Height: _____ Weight: _____

Short Questionnaire?

1. Do you have any kind of allergy / sensitivity to any food product etc?……..……
2. If YES, to what?_____
3. What type of reaction?
    1. RASH HIVES NAUSEA SWELLING TROUBLE BREATHING

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4. Do you take any medicine everyday? (Including Aspirin, Birth Control, High BP, Diabetes etc?
    1. IF YES, Which one?_____
5. Do you take any herbal products, diet pills, over the counter products?

    …….
6. Have you ever smoked cigarettes?……
    1. a. How many _____ b. For How long?_____ c. Do you smoke now?_____
7. Do you drink alcohol?……
    1. How Often? _____ b. What Kind?_____ c. How Much?_____

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8. Have you ever had a:
    1. Heart Attack?
    2. Heart condition?
    3. Chest pain?
    4. High blood pressure?
    5. Shortness of breath?
    6. Pressure in your chest?
    7. Palpitation or irregular heart beat?
    8. Abnormal ECG?
9. Do you snore?……..

10. Do you suspect to have sleep apnea?…….

11. Do you wake up at night short of breath?……...

12. Do you have difficulty breathing while climbing stairs?…….……...

13. Can you lie flat on bed without getting short of breath?……...

14. Do you have high blood sugar content? IF YES how much?……...

15. Do you have history of asthma, bronchitis, wheezing or tuberculosis?……..……...

16. Do you ever had abnormal chest X-ray?……...

17. Recent cough & Cold?……..……...

18. Do you have any problem with liver?……..……...

19. Have you ever had hepatitis or jaundice?……...

20. Have you ever had stomach ulcers?…….……...

21. Have you ever had mouth ulcers?…….……...

22. Have you ever had Kidney stones?……...

23. Have you ever had thyroid problem?…….……...

24. Do you have constipation or loose stool?…….……...

25. Have you ever dizziness, weakness in your arms and legs?…….……...

26. Does your arms or legs gets numb?……..……...

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27. Do you feel pain in your nails?…….……...

28. Do you have a problem of joint pains?……..……...

29. Is your skin oily or dry?…….……...

30. Are you planing pregnancy?……...

31. Do you have split hair?…….……...

32. How much is your hair fall?…….……...

33. Do you forget things often?……...

34. Do you gave anaemia, bleeding problem or nose bleed?……...

35. Have any of your family members have/had any of the above problems?……...

Any Condition we did not ask you about?……..……...

If Yes, What?

Declaration:

"Healthy living" means both physical and mental health are in balance or functioning well together in a person. In many instances, physical and mental health are closely linked, so that a change (good or bad) in one directly affects the other. All humans have to eat food for growth and maintenance of a healthy body, but we humans have different nutrition requirements as infants, children (kids), teenagers, young adults, adults, and seniors. For example, infants may require feeding every 4 hours until they gradually age and begin to take in more solid foods. Eventually

they develop into the more normal pattern of eating three times per day as young kids. Being healthy should be part of your overall lifestyle. Living a healthy lifestyle can help prevent chronic diseases and long-term illnesses. Feeling good about yourself and taking care of your health are important for your self-esteem and self-image. Maintain a healthy lifestyle by doing what is right for your body. It includes Power of Attitude- A positive attitude can boost your energy, heighten your inner strength, inspire others, and garner the fortitude to meet difficult challenges. Exercise & Physical Therapy - Advice on aerobic, flexibility, strength training and balance exercises to help manage and reduce PN symptoms. Nutrition - Good nutrition is often the first line of defense to avoid many diseases, including peripheral neuropathy. Find advice for keeping a healthy diet, shopping and managing drug side effects and Self-Care & Coping Skills. In order to have a sound mental and emotional state, one must surround with positive energy. Yes, not all problems can be avoided. But it helps to face such obstacles with an optimist outlook. It also means avoiding tobacco, alcohol and other inducing substances. Dr. Veerendra Aryavrat is a healthy life expert and he takes a holistic approach to wellness. His tips supports a person to live a healthy lifestyle. The foundation of advice is based on the importance of a healthy diet, clean fresh water, sunlight, exercise and stress management. He educates the person to look after their own health and the health of their family , supporting the body's capacity to heal, and balancing the body so that illness is less likely to occur in the future. A range of advices are used to support the person. These include diet advice, herbs, lifestyle advice, and tactile, such as massage, acupressure or yoga. I understand that the food & herbs need to be consumed. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify Dr. Aryavrat of any unanticipated or unpleasant effects associated with the consumption of the herbs/food. I do not expect him to be able to anticipate and explain all possible risks and complications, and I wish to rely on the the exercise of judgment during the course which is based upon the facts then known. The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of healthy living lifestyle, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach-ache, vomiting, headache, diarrhoea, rashes, hives and tingling of the tongue. I acknowledge that no homeopathic medicines, allopathic medicines nor any controlled substances are prescribed to me. I understand that results are not guaranteed. By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment form, have been told about the risks and benefits of healthy living lifestyle process, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s)for which I seek treatment. All the food products that have been advised are naturally occurring and are used in day to day basis and have no side effects however I will immediately stop the uses in case of any unforeseen allergy /sensitivity.

(Female only) Are you pregnant?Yes/No If yes how many weeks? _____

Name…… Signature……

Detailed questionnaire

Gastro-intestinal	Respiratory	Skin	Cardiovascular
□ Bloating □ Flatulence □ Reflux/Heartburn □ Indigestion □ Nausea □ Abdominal pain □ Constipation □ Diarrhea □ Food intolerances	□ Persistent cough □ Sneezing, wheezing □ Post nasal drip □ Ear infections □ Itchy eyes, ears, nose, throat □ Sore throat	□ Slow wound healing □ Acne □ Psoriasis □ Dry, flaky skin □ Oily skin □ Eczema / skin rashes	□ Excessive fatigue □ Shortness of breath □ Easy bruising or bleeding □ Palpitations □ Dizziness □ Varicose veins □ High blood pressure □ High cholesterol
Immune/Lymphatic	**Sleep**	**Emotional**	**Musculoskeletal**
□ Poor immunity □ Recurrent cold / flu □ Hayfever / sinusitis □ Fluid retention □ Cold sores □ Inflammed / bleeding gums □ Auto-immune disease □ Cancer	□ Insomnia □ Difficulty falling asleep □ Waking during night □ Waking un-refreshed □ Regular dreaming □ Night sweats	□ Depression □ Anxiety □ Mood swings □ Poor memory □ High stress levels □ Feelings of being overwhelmed or unable to cope	□ Headaches □ Migraines □ Muscle aches or cramps □ Joint pain □ Restless legs □ Muscle weakness
Endocrine	**Urinary / Renal**	**Male hormone balance**	**Female hormone balance**
□ Fatigue / poor energy □ Recent weight gain □ Heat / cold intolerance □ Hair falling out □ Abdominal weight gain □ Thyroid disorder	□ Excessive urination □ Frequent urination □ Pain with urination □ Incontinence □ Bloody, cloudy or smelly urine□ Urinary tract infection_	□ Low libido □ Difficulty starting urine flow □ Premature ejaculation □ Difficulty maintaining erection □ Genital rash or irritation □ Painful testicles	□ Hot flushes □ Night sweats □ Change in menstrual cycle □ Dry hair, skin or vagina □ Low libido □ Excessive libido □ Bleeding after intercourse □ Infertility □ Miscarriage

Pre-menstrual symptoms (women only)	Menstrual symptoms (women only)	Sexual Health	Lifestyle
□ Depressed or teary □ Anxious or irritable □ Feeling aggressive or angry □ Breast tenderness □ Food cravings □ Fluid retention/ bloating □ Back pain □ Abdominal pain □ Headaches or migraines	□ Long intervals between cycles □ Cycles longer than 32 days □ Cycles shorter than 24 days □ Heavy blood flow or flooding □ Passing of blood clots □ Very light blood flow □ Spotting before or after bleed □ Period pain	□ Thrush □ Genital herpes □ Sexually transmitted disease □ Irregular pap smear □ Painful intercourse □ Burning or itching pain on genitals	□ Smoker _____ / day □ Passive smoker □ Coffee _____/ day □ Tea _____/ day □ Alcohol _____ / week □ Recreational drugs □ Exercise ___ / week □ Excessive plane travel □ Radiation exposure □ Pesticide / herbicide exposure □ Bleach and ammonia use (cleaning) □ High stress levels