Ayuryoga Mantra,

London, NW9 4BL

AYM PATIENT REGISTRATION FORM

1. Full Name & Contact details (Mobile, Address, Email)

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1. Age-DOB……

3. Sex: ……..

4. Height (cm)……

5. Weight (kg)……..

6. Blood Group……

7. Chief/Main Complaint:

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8. Associated/Other Complaints

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9. Past History of any illnesses/treatments or procedure with year:

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10. Family History of any illnesses:

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11. Specific Blood reports / Important diagnos c test reports with date in last 5 years:

12. Bowel Movement: (Consitpated / Regular & normal/ Frequent & disturbed)……

13. Appe te: (Low/Medium/High)

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14. Menstrual History: Regular/Irregular/any other complica ons; History of Pregnancies

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15. Urine: Colour, frequency/burning

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16. Sleep: (Regular/sound/disturbed)

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17. Stress levels/reasons

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18. Physical ac vity if any

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19. Medicine/herbal/diet history

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20.
Allergies……
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21. Skin Allergies if
any……
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22. Immunity:

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23. Nail
:Texture……
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24. Hair Texture/ Hairfall / Dandruff:

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25. Skin texture and tendencies:

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26. Diet rou ne with Timings:

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27. Eyesight:

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28.
Temperament:……
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29. Tongue (Coated /Clear/ Colour)

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30. Pulse rate: ……..

31: Bone-health……..

32: Diges on: ……

33: Gas/ Acidity……..

34: Daily Water Intake: ……..

35: Ou ngs/Dining out frequency per week ……..

CONSENT:

I am aware of the scope of Ayurveda and Yoga, and in case of joining the treatment program with my free will and research.

I'm aware of the potential benefits and risks involved in treatments of various modalities.

I am aware that I can discontinue or choose another mode of treatment at any stage of the healing process with my own choice and free-will.

I understand that there can be variations in results of two different individuals and the way they respond to the treatment.

I am aware that I have the right to full information about the contents of the treatment given to me.

I'm aware that my health data in case of my joining will be recorded and saved for future references and research.

I'm aware that all treatment modalities are based on evolving sciences and research. And my clinician will only plan treatments based on their educational background and experience.

Date, Place:

Signature: