WELLSPRINGHEALTH

**Name: _____ Date: _____**

Have you recently lost or gained a significant amount of weight? No Yes
If so please explain: _____

**Elimination:**

How often do you have bowel movements?
More than 3 times a day 2-3 times per day Once daily Every other day
Less than once every 3 days

When do you usually have bowel movements?
First thing in the morning Later in the morning In the afternoon Immediately after meals
At night after dinner

Stools are usually:
Soft Medium Hard

Do you frequently use enemas or laxatives?
No Yes If so, how often? _____

Have you recently experienced any increase or decrease in frequency of bowel movements or urination?
If so please describe: _____

Do you get up in the middle of the night to urinate? If so, how many times? _____

Have you recently experienced any discomfort with bowel movements or urination?
If so please describe: _____

**Sleep:**

What time do you go to sleep?
What time do you wake up?
Do you take naps in the daytime? Yes No
What is the quality of your sleep? (Choose as many as apply)
Sound; normal duration Light, interrupted Too little sleep Too heavy and/or too long
Difficulty falling asleep Difficulty waking up Awakening too early Frequent nightmares
Other: _____

Dietary Habits:

Which is your main meal of the day?
Breakfast Lunch Dinner

What time do you eat lunch?
What time do you eat dinner?
Is your digestion: Good Fair Poor
After meals do you feel any of the following? Bloated/Distended Sleepy Heavy Burning
Is your diet:
Vegetarian Mostly Vegetarian Non-vegetarian
Do you eat between meals? Yes No
What do you eat for breakfast?
What do you eat for lunch?
What do you eat for dinner?
How often do you microwave your food?
How often do you eat leftovers?
Are there any foods that cause you discomfort?
Sweet Sour Salty Hot/Pungent Bitter Astringent

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Oily/Fatty Dairy products (including cheese)

**Name: _____ Date: _____**

Do you drink caffeinated beverages? No Yes If so which ones and how often?
Do you drink carbonated beverages? No Yes If so how often?
Do you smoke? No Yes If so how many packs per day? ½ 1 2 more than 2
How often do you drink alcohol?
Never Less than once a week About once a week
Several times a week About once a day More than once a day

Daily Routine:
How regular is your daily routine (for example, do you go to bed early, eat your meals on time, exercise, regularly, etc)?
Very regular Not very regular Somewhat regular Very irregular
Do you eat your meals on time? Yes No
How often do you exercise?
Regularly Occasionally Never
What time of the day do you exercise?
Is your exercise:
Vigorous Moderate Light None
Do you travel a lot? Yes No

**Stress Level:**
What is your present state of mind and emotions?
Good Fair Poor
Do you often feel fatigued?
in the body in the mind both neither
Do you tend to worry? No Yes
Do you tend to get angry or frustrated easily? No Yes
How would you rate your usual energy level as compared to most people? On a scale from 1 to 10, with 1 being very low energy, 5 being average, and 10 being very high energy:
Please circle one:
1 2 3 4 5 6 7 8 9 10
Low medium high

**Environmental History:**
Do you work a lot with computers?
Yes No
Do you work with chemicals or in a polluted environment?
Yes No
Do you practice a meditation technique? Yes No If yes, which technique?
Are you regular in your practice? Yes No
Which type of weather makes you feel most uncomfortable?
Cold Hot Cool and damp
What is the environment of your place of residence? Wet with thick vegetation Coastal area
Dry, arid area Desert area Windy area Other _____

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**Name: _____ Date: _____**

Ama Questionnaire

Below is a series of questions that helps to determine if you have a buildup of ama in your body.

| | | 0% | 25% | 50% | 75% | 100% |
|---|---|---|---|---|---|---|
| 1 | I tend to feel obstruction/blockages in my body—constipation, congestion/heaviness in the head area, blocked nose, general feeling of non-clarity. | | | | | |
| 2 | When I wake up in the morning, I do not feel clear; it takes me quite some time to feel really awake. | | | | | |
| 3 | I tend to feel tired or exhausted mentally and physically. | | | | | |
| 4 | I get common colds or similar ailments several times a year. | | | | | |
| 5 | I tend to feel heaviness in the body. | | | | | |
| 6 | I tend to feel that something is not functioning properly in the body—breathing, digestion, elimination, or other. | | | | | |
| 7 | I tend to feel lazy, i.e., the capacity to work is there, but there is no inclination. | | | | | |
| 8 | I often suffer from indigestion. | | | | | |
| 9 | I tend to spit repeatedly or have a bad taste in my mouth. | | | | | |
| 10 | Often I have no taste for food and no real appetite. | | | | | |
| 11 | My tongue is often coated with a thick film, especially in the morning. | | | | | |

**Section for Women:**

**Menstrual history:**

Age of onset: _____

Date of last period: _____

Which of the following describes your menstruation:

Regular Irregular Painful Too frequent Infrequent Ceased due to menopause

Is your menstrual flow?

Heavy Light Normal

**Pregnancies:**

Are you pregnant? Yes No Don't know

Have you ever been pregnant? Yes No

Number of pregnancies? _____

Number of children? _____

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