# DIGESTION ASSESSMENT BY DOSHA PREDOMINANCE

| Question | Relative Score | Vata | V | Pitta | P | Kapha | K |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Is your hunger | 1 | Irregular, varies from meal to meal. | | Generally strong; cannot skip meals. | | Mild; can generally easily skip meals. | |
| After eating, speed of digestion (time it takes to feel hungry again) is | 1 | Irregular, varies from meal to meal. | | Quick; I feel hungry again after only a couple of hours. | | Slow; I'm not hungry again for 5-6 hours. | |
| Food capacity (amount you can eat at a time) | 1 | Varies from meal to meal. | | Large as compared to most other people. | | Small as compared to most other people. | |
| Fluctuations of body weight | 1 | Easy to lose, difficult to gain; I tend to be underweight. | | Can maintain normal weight even with fairly large food intake. | | I gain weight easily, even with moderate food intake. Difficult to lose weight. | |
| Energy level | 1 | Variable or low compared to others. | | Abundant compared to others. | | Good, but may tend toward laziness. | |
| Regularity of bowel movements | 1 | Irregular, tending toward constipation. | | Frequent; often more than 1-2 times a day. | | Regular, once or twice daily. | |
| Quality of stool | 1 | Hard, dry. | | Loose. | | Well-formed. | |
| Add 1 point for each of the symptoms listed | 1 per each symptom | a. Gas or bloating<br>b. Frequent belching<br>c. Constipation<br>d. Intestinal cramping or discomfort | | a. Acid stomach<br>b. Reflux (heartburn)<br>c. Diarrhea tendency | | a. Sluggish digestion (regularly, not variable)<br>b. Heaviness or sleepy after eating (often)<br>c. Stool sticky or with mucus | |
| **Totals for V-P-K** | | | | | | | |

# General Health Survey

Please mark to what degree the following statements apply to you (1=0% and 5=100%)

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

*Maharishi Ayurveda*
*Initial Client Questionnaire*

**Date:** _____

**Personal Data:**

Name: _____

Address: _____

City or Town: _____

State: _____ Zip Code: _____

Country: _____

E-mail address: _____

Telephone (home): _____

Telephone (work): _____

Telephone (cell): _____

Fax number: _____

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Gender: ____ Male ____ Female

Age_____ Birth date: _____

Marital Status: Married Single Divorced Widowed

Occupation: _____

Are you ALLERGIC to, or intolerant of, any HERBS, SPICES, FOODS or DRUGS? Please list below:

What are your goals for your wellness consultation today?

Do you currently engage in any activities that could compromise your health or would be considered "unhealthy"?

Do you have any current health concerns or problems?

Any significant previous health concerns or problems?

Initial Client Questionnaire

Any significant family history of health problems?

Please list all prescription medications, birth control pills, hormone replacement therapy, vitamins or other supplements that you are taking:

_____

_____

Please list foods you typically eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

Any special dietary needs?

_____

**Previous Ayurvedic evaluations and treatments:**

List date and place of most recent previous Ayurvedic evaluation, if any:

_____

List date and place of most recent in-residence Ayurvedic programs, if any:

_____

**Body Weight:**

Height: ____ ft. ____ in. Weight: Now _____, 1 year ago _____
Maximum_____ When? _____ Minimum _____ When? _____
Any weight gain or loss in the past 6 months? (# of pounds, + or -)_____

Initial Client Questionnaire

**Digestion:**

1. Is your digestion: ___ Good ____Fair ____Poor
2. Is your appetite: ____ Strong ___ Moderate ___Mild ___Variable
3. In general, how is your energy during the day? ___ Strong ___ Medium ___ Low ___ Variable
4. Do you often feel heavy after eating? ___ Yes ___ No
5. Do you often feel sleepy after eating? ___ Yes ___ No
6. Do you have problems with (please circle):
   Gas flatulence belching bloating heartburn acid indigestion reflux
   Other:
7. Are there any foods that cause discomfort? _____

**Elimination:**

1. Do your bowel movements tend to be?
   ____ Regular ____ Irregular
2. How often do you have bowel movements?
   ____ More than 3 times a day ____ 2-3 times per day
   ____Once daily ____Less than once every 3 days
3. 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
4. Stools are usually:
   ____Soft ____Medium ____ Hard ____ Variable consistency
5. Do you use enemas or laxatives?
   ____No ____ Yes How often? _____
6. Do you have hemorrhoids?
   ____ No ____ Yes If yes, do they bleed? _____

**Diet and Eating Behavior:**

1. Is your diet:
   _____ Non-vegetarian ____ Mostly Vegetarian ____Vegetarian
2. Which is your main meal?
   ____ Breakfast ____ Lunch ____ Dinner
3. Do you eat between meals? ____ Yes ____ No
4. How much time do you take for: Breakfast _____ Lunch_____ Dinner_____
5. Do you sit for 5-10 minutes after finishing a meal (circle one)? ____ Yes ____ No
6. Do you feel you now have or had in the past an eating disorder? ____ Yes ____ No

7. How often do you eat the following?
   a. Leftovers? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   b. Frozen foods? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   c. Packaged/processed foods? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   d. Cold foods and/or drinks? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   e. Raw vegetables (salad)? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   f. Red meat? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   g. Spicy foods? ____ Often ____ Sometimes ____ Rarely ____ Almost never

8. How many times per week do you eat out in a restaurant? _____
9. How often do you microwave your food or drinks? ____ Often ____ Sometimes ____ Rarely ____ Almost never
10. About what percentage of your food is organically grown? _____
11. How many soft drinks or diet soft drinks do you drink each week? _____
12. What kind of water do you drink? _____

**Sleep:**

1. Is your sleep disturbed?
   ____ Not at all ____ Somewhat ____ Moderately
   ____ Severely ____ Very Severely
2. Do you take sleep aids? _____
3. What time do you usually go to bed (lights out)? _____
4. What time do you usually wake up? _____
5. Are your bedtime and arising times regular from day to day?
   ____ Very Regular ____ Mostly regular ____ Somewhat regular ____ Mostly irregular

**Daily Routine:**

1. How regular is your daily routine (for example, do you go to bed, get up, and eat your meals around the same time daily)?
   ____ Very regular ____ Not very regular
   ____ Somewhat regular ____ Very irregular
2. Do you go to bed early (by 10:00-10:30 p.m.)? ____ Yes ____ No
3. Do you get up early (by 6:00-6:30 a.m.)? ____ Yes ____ No
4. Do you eat your meals on time? ____ Yes ____ No
5. How often do you exercise?
   ____ Regularly ____ Occasionally ____ Never
6. What type of exercise do you do, if any? _____
7. Is your exercise?
   ____ Vigorous ____ Moderate ____ Light ____ None

8. Do you practice meditation? ____ Yes ____ No
   a. How often? ____ Regularly ____ Occasionally ____ Never
   b. What kind? _____
9. Do you take daytime naps? ____ Often ____ Sometimes ____ Rarely ____ Almost never
10. Do you travel a lot? ____ Yes ____ No
11. How often do you:
    a. Smoke: _____
    b. Drink alcohol: _____
    c. Drink caffeinated beverages: _____
12. Do you feel you take enough time for yourself? ____ Yes ____ No
13. How many hours per day do you use a computer? _____
14. How many minutes per day on a cell phone? _____
15. Are you having work or family problems that are impacting your health? ____ Yes ____ No
16. Do you perform "cleansings"? ____Yes ____ No Describe: _____

**Psychology**

1. How would you describe your mood? _____
2. Do you suffer from? (circle relevant) anxiety, depression, anger, mood swings
3. Are you currently in psychological counseling? ___ Yes ____ No

**Environment**

1. What direction does your house face? (N/NE/E/SE/S/SW/W/NW) _____
2. What side of the house do you enter? (N/NE/E/SE/S/SW/W/NW) _____
3. What direction does your head of your bed point towards? (N/NE/E/SE/S/SW/W/NW) _____
4. Do you live near a power plant or high tension wires? ____ Yes ____ No
5. Are you exposed to chemicals, pesticides or other toxins on a regular basis? ____ Yes ____ No
6. Have you recently painted or renovated your home or office? ____ Yes ____ No

**Section for Women**

Menstrual History:
Age of onset: _____
Date of last period: _____
Date of last GYN exam: _____ Any abnormalities? ____ Yes ____ No
(If yes, describe) _____
Do you take birth control pills? ____ Yes ____ No
Length of time taking: _____

Initial Client Questionnaire

1. Which of the following describes your menstruation? (Choose as many as apply)
   ____ Regular ____ Absent ____ Irregular ____ Too frequent
   ____ Infrequent ____ Ceased due to menopause

(If you are post-menopause, please skip to Question 5)

2. How many days does your menstrual period last?
   ____ Zero to four days ____ Five to seven days
   ____ More than seven days ____ Spotty/irregular

3. Is your menstrual flow?
   ____ Heavy ____ Light ____ Normal

4. Associated symptoms (before or during Menstruation):
   ____None ____ Fluid retention ____ Pain ____ Acne Other_____

5. Do you have any discharge outside of your menstrual period?
   ____ Yes ____ No

6. Do you have any itching of vaginal area?
   ____ Yes ____ No

7. Pregnancies:
   Are you pregnant now? ____ Yes ____No ____ Don't know
   Number of children:_____
   Number of pregnancies: _____
   Describe any complications with pregnancy:
   _____