Sattva Strong LLC

Discover a harmonious blend of yoga and Ayurveda for a balanced lifestyle that is unique to YOU. Embrace wellness through movement and holistic practices at Sattva Strong.

Confidential Client Interest Intake Forms

CONTACT DETAILS

Name _____ Age _____

Address _____ Sex _____

Email Address _____ Phone _____

Ethnicity ☐ South Asian ☐ Native American ☐ Mediterranean ☐ Caucasian ☐ Other
☐ Hispanic ☐ Northern European ☐ African-American ☐ Asian

PERSONAL HEALTH / CONCERNS

Kindly provide an account of your current health concerns and/or wellness goals

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____

For how long have you been focusing on your health and wellness goals before seeking consultation?

☐ Less than 6 Months ☐ 6 Months to 2 Years ☐ 2-5 Years ☐ More than 5 Years

Could you please detail the progression of your health goals since identifying them

☐ Gradually Improving ☐ Rapidly Improving ☐ Fluctuating
☐ Gradually Worsening ☐ Rapidly Worsening ☐ Stable

DAILY ROUTINE & HABITS

Do you get up early? ☐ Yes ☐ No ☐ At what time? _____

Do you go to bed early? ☐ Yes ☐ No ☐ At what time? _____

Do you sleep in the daytime? ☐ Yes ☐ No

How would you describe your general state upon waking up in the morning?

☐ Fresh and rested ☐ A little tired ☐ Moderately tired ☐ Fairly tired

Which direction does your head typically face while you sleep?

☐ North ☐ South ☐ East ☐ West

☐ North-East ☐ North-West ☐ South-East ☐ South-West

How would you describe the quality of your sleep?

☐ Sound, normal duration ☐ Light, interrupted ☐ Too little sleep

☐ Too heavy and/or too ☐ Difficulty falling asleep ☐ Difficulty waking up

☐ Awaken too early ☐ Frequent nightmares

What position do you typically sleep in?

☐ Left Side ☐ Right Side ☐ On Back ☐ On tummy

☐ Other _____

_____

_____

DAILY ROUTINE & HABITS

How consistent is your daily routine? For instance, do you maintain regular bedtimes, adhere to meal schedules, and engage in consistent exercise?

- [ ] Very Regular
- [ ] Somewhat Regular
- [ ] Irregular

Please describe your bowel movements:

- [ ] Once every 2-3 days
- [ ] Once daily
- [ ] 2-3 times per day
- [ ] First thing in morning
- [ ] Late in daytime
- [ ] Immediately after meals
- [ ] Immediately after dinner
- [ ] Need laxative daily
- [ ] Other

Bowel Nature:

- [ ] Hard
- [ ] Soft
- [ ] Medium

Bowel movement associated with:

- [ ] Pain
- [ ] Gas
- [ ] Blood
- [ ] Mucus
- [ ] Foul Smell

Do you intentionally delay or suppress any of the following activities?

- [ ] Bowel movement
- [ ] Sleep
- [ ] Gas
- [ ] Semen
- [ ] Thirst
- [ ] Breathing
- [ ] Urination
- [ ] Hunger
- [ ] Crying, Tears
- [ ] Sneezing
- [ ] Yawning
- [ ] Buying

Do you travel a lot?

- [ ] Yes
- [ ] No

Do you oil massage daily?

- [ ] Yes
- [ ] No

EXERCISE

How frequently do you engage in physical exercise?

- [ ] Weekly four times
- [ ] Weekly three times
- [ ] Weekly twice
- [ ] Weekly once
- [ ] Daily
- [ ] Not at all

What specific types of exercies do you participate in?

_____

_____

_____

How long do you exercise each time?

_____

_____

_____

Rate the intensity of your exercise: [ ] Light [ ] Moderate [ ] Vigorous

Do you participate in any sports [ ] Yes [ ] No

If yes, please explain:

_____

_____

Do you experience any discomfort or pain during or after exercise? Please Elaborate:

_____

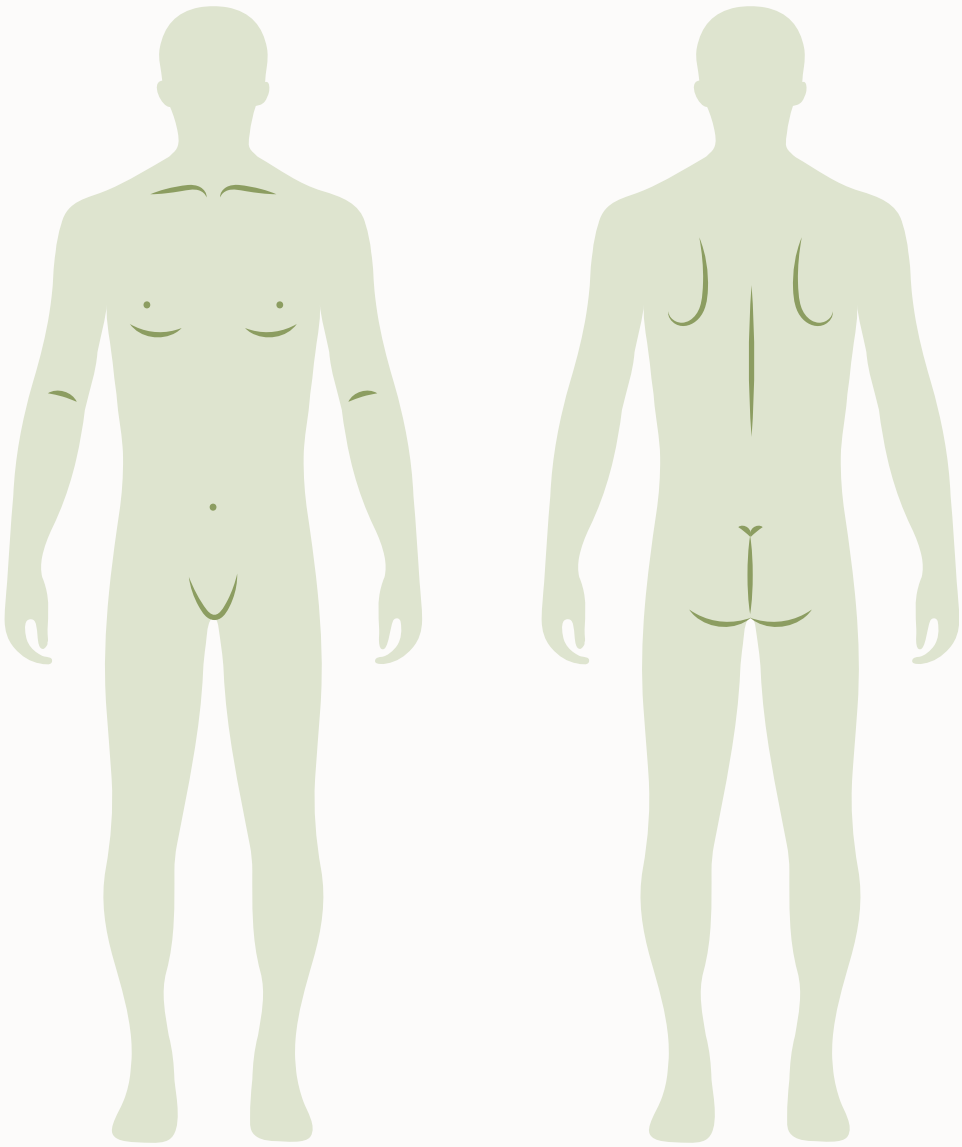
_____

_____

PERSONAL HEALTH

For Males

Do you currently experience any pain or discomfort when exercising or moving? If so, please indicate by circling areas of pain on the diagram provided below. Additionally, mark any areas of numbness or tingling with an "X".

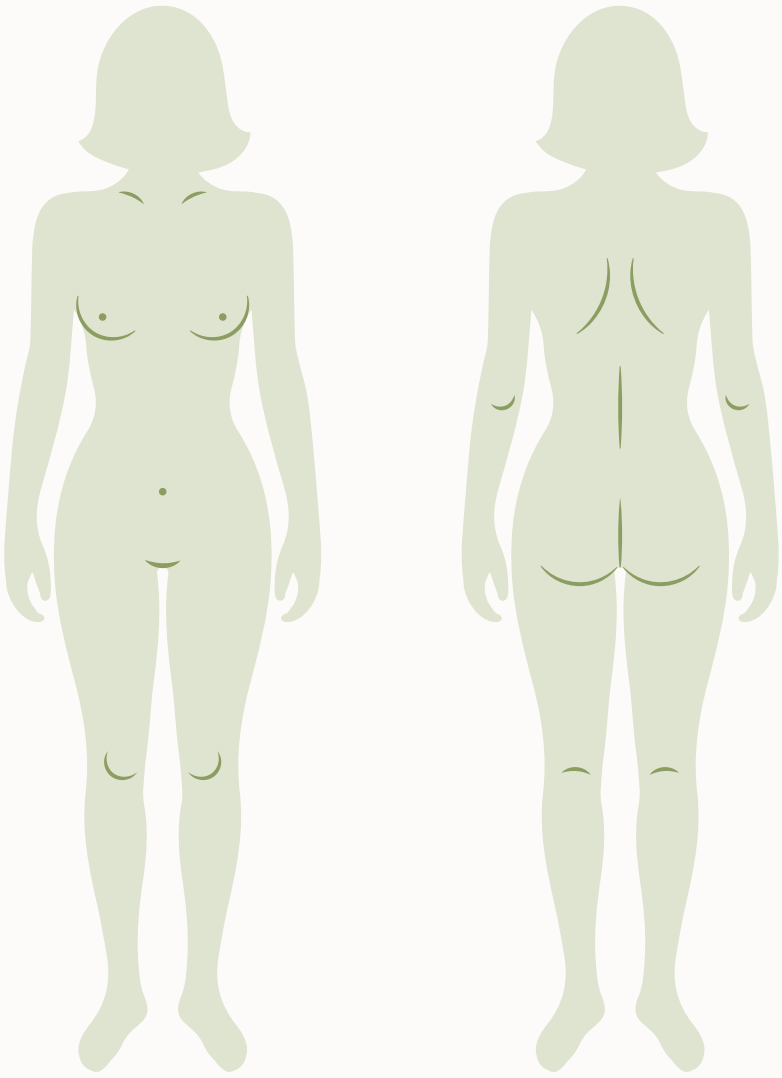


Sensations/Pain
1 Sharp
2 Tingling
3 Burning
4 Dull
5 Moves
6 Severe
7 Shooting
8 Numbness

PERSONAL HEALTH

For Females

Do you currently experience any pain or discomfort when moving or exercising? If so, please indicate by circling areas of pain on the diagram provided below. Additionally, mark any areas of numbness or tingling with an "X".



Sensations/Pain
1 Sharp
2 Tingling
3 Burning
4 Dull
5 Moves
6 Severe
7 Shooting
8 Numbness

EATING HABITS / DIET

FOOD GROUP	DAILY	WEEKLY	MONTHLY	NEVER
Grain/Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar				
Juices				
Others				

Could you please provide a description of your typical diet?

Breakfast

Lunch

Dunner

Snacks

EATING HABITS / DIET

Do you eat between meals? ☐ Yes ☐ No

Do you eat meal at regular time? ☐ Yes ☐ No

Indicate your eating habits

☐ Eat very quickly ☐ Rarely sit down to eat ☐ Watch TV while eating

☐ Converse while eating ☐ Eat with my full attention on eating

Rate your digestion ☐ Good ☐ Fair ☐ Bad

What's your biggest meal? ☐ Breakfast ☐ Lunch ☐ Dinner

How much water do you drink per day?

☐ None ☐ 1-2 Glass ☐ 3-4 Glass ☐ 5-6 Glass

☐ 7+ Glass

Describe your diet: (Vegetarian)

☐ Vegan ☐ Lacto-vegetarian ☐ Lacto-ovo

☐ Other _____

If you consume non-vegetarian foods, could you please specify the sources of protein you typically include in your diet?

☐ Beef ☐ Pork ☐ Turkey ☐ Seafood

☐ Chicken ☐ Eggs ☐ Others _____

EATING HABITS / DIET

Please indicate which will best describe and characterise your sense of taste, if applicable

- [ ] Loss of taste
- [ ] Sweet taste
- [ ] Sour taste
- [ ] Pungent taste
- [ ] Bitter taste
- [ ] Others _____

Do certain foods cause you discomfort when consumed? If yes please tick

- [ ] Sweet
- [ ] Salty
- [ ] Sour
- [ ] Bitter
- [ ] Astringent
- [ ] Dairy Products
- [ ] Other _____

Do your practice any type of meditation? Please explain:

_____

_____

Do you practice yoga? Please explain:

_____

_____

What type of weather do you find most uncomfortable?

- [ ] Cold
- [ ] Hot
- [ ] Cool & Damp
- [ ] Rainy

Do you have any known allergies to specific substances?

- [ ] Food
- [ ] Pollen
- [ ] Dust
- [ ] Other _____

_____

EATING HABITS / DIET

Do you smoke substances? ☐ Yes ☐ No

If yes, how many per day?

☐ 1/2 pack ☐ 1 pack ☐ 2 packs ☐ 2+ packs

How frequently do you consume alcohol?

☐ Never ☐ once a month ☐ Once a week ☐ 2-5 times a week

☐ Once a day ☐ 1+ in a day ☐ Other _____

How often do you consume beverages containing caffiene?

☐ Never ☐ 1 cup daily ☐ 2-3 cups daily ☐ 4-5 cups daily

On a scale from low to high, how would you rate your typical energy levels?

☐ Very high ☐ High ☐ Moderate ☐ Low

☐ Very Low

Could you please specify which symptoms or experience you are referring to?

☐ Depression ☐ Anxiety ☐ Fear or panic ☐ Loneliness

☐ Worry ☐ High stress ☐ Anger ☐ Irritation

☐ Lack of memory ☐ Lightness ☐ Lack of energy ☐ Confusion

☐ Suicidal thoughts or attempts

☐ Other _____

_____

EATING HABITS / DIET

How are your family relationships?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

How is your social life

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

How is your mental health?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

How is your career

- [ ] Love it
- [ ] Like it
- [ ] Its bearable
- [ ] Its unbearable

How purposeful does your life feel?

- [ ] Completely
- [ ] Somewhat
- [ ] Neutral
- [ ] Purposeless

Rate your spiritual life:

- [ ] Fully satisfying
- [ ] Somewhat
- [ ] Neutral
- [ ] Empty

Do you notice any patterns of emotional eating, such as eating when stressed, bored, or upset?

- [ ] Yes
- [ ] No

If yes, please explain:

DOSHA QUIZ

CHARACTERSTICS	VATA	PITTA	KAPHA
Body Frame	Small ☐	Medium ☐	Large ☐
Body Temp	Low ☐	High ☐	Moderate ☐
Body Weight	Slight ☐	Moderate ☐	Heavy ☐
Skin & Hair	Dry & Slim ☐	Moderate ☐	Thick & Oily ☐
Appetite	Inconsistent ☐	Strong ☐	Steady ☐
Stamina	Mild ☐	Average ☐	Enduring ☐
Sleep	Light ☐	Sound for short time ☐	Deep Sleep ☐
Stress	Anxious ☐	Impatient ☐	Unmotivated ☐
Daily Routine	Flexible ☐	Challenging ☐	Consistent ☐
Personality	Creative ☐	Dynamic ☐	Loving ☐
Speech Speed	Fast ☐	Medium ☐	Slow ☐
Walking Speed	Fast ☐	Medium ☐	Slow ☐
Focus	Cannot Focus ☐	Ambitious ☐	Highly Focused ☐
Memory	Remembers &then Forgets fast ☐	Moderate ☐	Slow Learning & never forgets ☐
Digestion	Irregular ☐	Strong ☐	Slow ☐
Eyes	Dry & Small ☐	Sharp & prone to redness ☐	Large & Watery ☐
Nails	Dry & Brittle ☐	Strong ☐	Thick ☐
Tongue	Dry & Thin ☐	Medium ☐	Large & Moist ☐

GUNA QUIZ

CHARACTERSTICS	RAJAS	SATTVA	TAMAS
Diet	Some Meat ☐	Vegetarian ☐	Heavy Meat ☐
Stimulants	Occassionally ☐	Never ☐	Frequently ☐
Sensory Impressions	Mixed ☐	Pure, Calm ☐	Disturbed ☐
Need for Sleep	Moderate ☐	Little ☐	High ☐
Control of Senses	Moderate ☐	Good ☐	Weak ☐
Speech	Agitated ☐	Peaceful ☐	Dull ☐
Cleanliness	Moderate ☐	High ☐	Low ☐
Work	For Personal ☐	Selfless ☐	Unmotivated ☐
Anger/ Fear	Sometimes ☐	Rarely ☐	Frequently ☐
Pride	Some Ego ☐	Modest ☐	Vain ☐
Speech Speed	Fast ☐	Medium ☐	Slow ☐
Depression	Sometimes ☐	Sometimes ☐	Frequently ☐
Contentment	Partly ☐	Usually ☐	Rarely ☐
Truthfullness	Most Times ☐	Always ☐	Rarely ☐
Honesty	Most Times ☐	Alwyas ☐	Rarely ☐
Peace of Mind	Most Times ☐	Generally ☐	Rarely ☐
Creativity	Partly ☐	High ☐	Rarely ☐
Attachment to Materials	Some ☐	Little ☐	A lot ☐

PRAKRTI QUIZ:
PREDOMINENT CHARACTERISTICS IN YOUTH

CHARACTERSTICS	VATA	PITTA	KAPAH
Mental Activity	Quick, Sharp, Restless ☐	Sharp, Critical, Aggressive ☐	Calm, Steady, Stable ☐
Memory	Short-term ☐	Generally Good ☐	Good Long-term ☐
Concentration	Weak ☐	Generally Good ☐	Very Good ☐
Ability to Learn	Quick ☐	Moderate ☐	Slow ☐
Dreams	Fearful, Active ☐	Fiery, Adventurous ☐	Watery, Romantic ☐
Sleep	Light ☐	Sound, medium ☐	Sound, heavy ☐
Speech	Quick, ☐	Sharp, Direct ☐	Slower, Clear ☐
Goals	Easily Distracted ☐	Focused, Driven ☐	Slow, Steady ☐
Works Best	Supervised ☐	Alone ☐	In Groups ☐
Weather Prefrence	Warm, Moist ☐	Cool, Dry ☐	Warm, Dry ☐
Eating Speed	Fast ☐	Medium ☐	Slow ☐
Stress Reactions	Excites Quickly ☐	Medium ☐	Slow to get Excited ☐
Routine	Dislikes ☐	Plans, Organizes ☐	Prefers Same ☐
Confidence	Timid ☐	Outwardly Confident ☐	Shy ☐
When Feeling Hurt	Cries ☐	Argues ☐	Withdraws ☐
Friendships	Clingy ☐	Jealous ☐	Secure ☐
Expresses Affection	With Words ☐	With Gifts ☐	With Touch ☐
When Threatened	Runs ☐	Fights ☐	Makes Peace ☐

VIKRTI QUIZ:
CURRENT STATE OF BEING

CHARACTERSTICS	VATA	PITTA	KAPAH
Mental Activity	Quick, Sharp, Restless ☐	Sharp, Critical, Aggressive ☐	Calm, Steady, Stable ☐
Memory	Short-term ☐	Generally Good ☐	Good Long-term ☐
Concentration	Weak ☐	Generally Good ☐	Very Good ☐
Ability to Learn	Quick ☐	Moderate ☐	Slow ☐
Dreams	Fearful, Active ☐	Fiery, Adventurous ☐	Watery, Romantic ☐
Sleep	Light ☐	Sound, medium ☐	Sound, heavy ☐
Speech	Quick, ☐	Sharp, Direct ☐	Slower, Clear ☐
Goals	Easily Distracted ☐	Focused, Driven ☐	Slow, Steady ☐
Works Best	Supervised ☐	Alone ☐	In Groups ☐
Weather Prefrence	Warm, Moist ☐	Cool, Dry ☐	Warm, Dry ☐
Eating Speed	Fast ☐	Medium ☐	Slow ☐
Stress Reactions	Excites Quickly ☐	Medium ☐	Slow to get Excited ☐
Routine	Dislikes ☐	Plans, Organizes ☐	Prefers Same ☐
Confidence	Timid ☐	Outwardly Confident ☐	Shy ☐
When Feeling Hurt	Cries ☐	Argues ☐	Withdraws ☐
Friendships	Clingy ☐	Jealous ☐	Secure ☐
Expresses Affection	With Words ☐	With Gifts ☐	With Touch ☐
When Threatened	Runs ☐	Fights ☐	Makes Peace ☐

STATEMENT OF UNDERSTANDING

- I understand that Deborah Bagocius of Sattva Strong LLC is an Ayurvedic Consultant and yoga instructor who provides me with information on the Ayurvedic approach and yoga movement to help facilitate wellness and wellbeing, which may positively influence my diet and overall health.

- I understand that Deborah Bagocius of Sattva Strong LLC is not a medical doctor or licensed medical practitioner, and has not presented herself as such. Additionally, I understand that she does not seek to diagnose, treat, or prescribe for diseases or other pathological conditions.

- I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought Ayurvedic consulting services.

- I agree that I may consult a licensed physician at any time for any concern regarding any disease or pathology that currently exists or arises during my professional relationship with Deborah Bagocius of Sattva Strong LLC.

- Furthermore, I understand that Deborah Bagocius of Sattva Strong LLC encourages regular medical checkups from a licensed medical professional of my choice. I acknowledge that any medication I am currently taking, upon the advice of my licensed physician, or may take in the future, must be strictly adhered to according to my licensed physician's directions. I understand that only a licensed physician of my choice can provide advice on medication dosages or the discontinuation or resumption of such medications.

Please provide your signature below to acknowledge that you have fully read and understood the above statements.

_____ _____

Client Signature **Date**