THE HEALING HOUSE OF ALACHUA

Omar Czenstochouski, CAP
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Name:	**Today's Date:**
Address:	**City, State & Zip:**
Home Phone:	**Cell Phone:**
Email:	**Referred by:**
Age & Date of Birth:	**Place of Birth:**
Occupation:	**Marital Status:**
Height:	**Weight:**
Sex:	**Ethnicity:**

Emergency Contact Information

Name:	**Phone:**

With whom do you live? *Include children, parents, pets, other occupants with ages:*

Main problem(s) & health concern(s) you would like to address:
Please describe in your own words what has moved you to seek help, not the name of your medical condition or diagnosis/es. Space has been provided for that after this chart on the next page.

Describe the problem in your own words	Since when	1-10 affecting daily life?	Attempted treatments & response

Are you diagnosed with any medical conditions?

Condition	Since when	Control status	Treating Physician

Were there previous diseases that you suffered from in the past?
Please include major infections like malaria, typhoid, hepatitis, etc.

Disease	Beginning/End Date	Treatment

Please list any hospitalizations

Year	Condition	Procedure performed

Have you had any kind of surgery or minor procedures performed on you?
Include any Panchakarma, Acupuncture and other treatments here as well.

Procedure	When	Performed by whom and where?

Are you taking any prescription medications?

Medication Name	Started in	Dosage	Prescribed by

Are you taking any herbal or alternative medicine?

Name	Started in	Dosage	Recommended by

Are you taking any vitamins or supplements?

Name	Started in	Dosage	Prescribed by

Family History *Mark with "X" if applicable*

	Diabetes	Hypertension	Stroke	Heart Disease	Asthma	Cancer (type)	Arthritis	Other
Father								
Mother								
Brother(s)								
Sister(s)								

Do you have any food sensitivities?

Do you have any allergies?

How much do you move/stretch/exercise? In the past 3-4 months

Activity	Intensity	Duration	Day per week	Since

Routine

How many times a week do you break a sweat?	
How many hours do you watch TV per week?	
Do you read or have screen-time while eating?	

How do you have fun? *Hobbies/Activities/Community*

How do you introspect/connect within? *Meditation/Prayer/Journaling/Etc.*

Have there been any recent events/changes creating stress in your life?

Habits: *Please indicate usage with an "X". Add comments where significant.*

	None	Light	Moderate	Heavy	Comments
Alcohol					
Coffee					
Tea					
Tobacco					
Marijuana					
Other					

In the past week: *Rate on a scale from 0-10 (0 = lowest and 10 = the highest)*

How stressed you have been?	
What is your energy level?	
Overall, how hungry do you feel at different meal times?	

In the past 3 or 4 months, Rate your general hunger levels with a number from 1-10.
1 = minimal, almost no hunger. 10 = an extreme amount of hunger.

	Morning	Mid-morning	Lunch	Afternoon	Dinner	Evening	Bedtime
Time of day							
Hunger							

Rate on a scale from 1-5: *1= Never, 2= Rarely, 3=Sometimes, 4=Often, 5=Always*

	1-5	*Practitioner use only*
Is the above-mentioned meal pattern irregular?		*Vata (Vishama)*
Can you skip meals easily?		*Kapha/Ama (Manda)*
Are you mostly always ready to eat -whatever time of the day it may be?		*Pitta (Tikshna)*
If very hunger, do you feel uncomfortable or irritable?		*Pitta (Tikshna)/ (Vata)*
Do you end up feeling fuller earlier than expected at the start of a meal?		*(Manda/Vishama)*
Are there times when even a little quantity of food doesn't get digested for a long time?		*Ama/Vata (Manda/Vishama)*
Does your food get digested well on some days and sometimes not?		*Vata (Vishama)*

Personal preference: *Please highlight your choice in yellow or draw a circle.*

Which extreme of weather are you unable to tolerate?	Hot / Cold / Neither
What weather do you prefer?	Warm / Cool / Both
Do you sweat easily?	Rarely / Not that much / Often
Generally, how thirsty do you feel?	Often / Moderate / Not much

Highlight yellow or fill in the circle any symptoms you have experienced in the last 3-4 months

General

- ◯ Poor appetite
- ◯ Weight gain
- ◯ Tremors
- ◯ Strong thirst -hot
- ◯ Cravings
- ◯ Weight loss
- ◯ Poor balance
- ◯ Strong thirst -cold
- ◯ Change in appetite
- ◯ Fatigue
- ◯ Localized weakness
- ◯ Fevers
- ◯ Peculiar taste/smell
- ◯ Night sweats
- ◯ Bleed/bruise easily
- ◯ Chills
- ◯ Sudden energy drop

Skin & Hair

- ◯ Rashes
- ◯ Hair loss
- ◯ Itching
- ◯ Dandruff
- ◯ Skin tags
- ◯ Pimples
- ◯ Hives
- ◯ Skin/hair changes

Head/neck

- ◯ Dizziness
- ◯ Headaches
- ◯ Poor balance
- ◯ Migraines
- ◯ Facial pain

Eyes, ears, nose and throat:

- ◯ Glasses
- ◯ Blurry vision
- ◯ Poor vision
- ◯ Grinding teeth
- ◯ Cataracts
- ◯ Sores on lips or tongue
- ◯ Color blindness
- ◯ Teeth problem
- ◯ Spots in vision
- ◯ Recurrent sore throats
- ◯ Cataracts
- ◯ Jaw clicks
- ◯ Eye pain
- ◯ Nose bleeds
- ◯ Night blindness
- ◯ Poor hearing
- ◯ Eye strain
- ◯ Spots in vision
- ◯ Ringing in ears
- ◯ Sinus problems

Cardiovascular:

- ◯ Swelling of feet
- ◯ Chest pain
- ◯ Blood clots
- ◯ Venous swelling
- ◯ Dizziness
- ◯ Cold hands
- ◯ Cold feet
- ◯ Low blood pressure
- ◯ Fainting
- ◯ Difficulty breathing
- ◯ Irregular heartbeat
- ◯ Other problems with heart

Respiratory:

- ◯ Cough
- ◯ Coughing blood
- ◯ Pain with deep breath
- ◯ Difficulty laying down

Musculoskeletal:

- ◯ Back pain
- ◯ Hand/wrist pain
- ◯ Foot/ankle pain
- ◯ Neck pain

○ Shoulder pain ○ Hip pain ○ Knee pain ○ Muscle weakness

Gastrointestinal:

○ Belching ○ Flatulence ○ Bloating ○ Nausea

○ Regular laxative use ○ Constipation ○ Diarrhea ○ Indigestion

○ Abdominal pain/cramps ○ Vomiting ○ Black stools ○ Blood in stools

Genito-urinary

○ Frequent urination ○ Urgency to urinate ○ Kidney stones ○ Excessive sexual urge

○ Pain on urination ○ Unable to hold urine ○ Blood in urine ○ Wake up to urinate

○ Reduced urination flow ○ Impotency

Neuropsychological:

○ Lack of coordination ○ Loss of balance ○ Concussion ○ Anxiety

○ Easily susceptible to stress ○ Depression ○ Area of numbness ○ Seizures

○ Treated for emotional conditions

Pregnancy and Gynecology:

○ Painful periods ○ Irregular periods ○ Clots ○ Vaginal sores

○ Unusually light/heavy ○ Premenstrual symptoms ○ Vaginal discharge ○ Breast lumps

Menses duration:	Length of full cycle:
Age at first menses:	Date of last menses:
Birth control type (if applies):	Using birth control since:
Number. of pregnancies:	Number of births:
Number of premature births:	Number of miscarriages:
Number of abortions:	Date of last PAP:

Is there any additional information you would like to share?

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Welcome to your Ayurvedic consultation. Your Ayurvedic consultation will be done by Omar Czenstochouski. Omar Czenstochouski is NOT A LICENSED PHYSICIAN OR MEDICAL DOCTOR. Ayurveda is also not licensed by the state of Florida as a medical discipline or practice. Ayurveda is the ancient wellness system of India. It is the Vedic teaching of natural living and it encompasses maintaining the harmony of the mind, body and soul through diet, lifestyle and natural herbal supplements. Ayurvedic protocols are never one-size fits all, but custom tailored for each individual. As an Ayurvedic practitioner, for educational purposes only, we will provide you with the traditional perspective of Ayurveda through classical ayurvedic assessments and corresponding recommendations in the following areas:

- Constitutional dosha Analysis (Prakrti)
- Current dosha imbalance (Vikrti)
- Diet
- Lifestyle
- Exercise/Yoga practices
- Herbal supplements
- Self-care practices
- Pranayama (Breathing practice & awareness)

Ayurveda is complementary to and supportive of conventional medicine. If you ever have any concerns about the nature of our meetings, please feel free to discuss them with me. I recommend that you inform your medical doctor that you are receiving Ayurvedic consultation.

I have read and understood the above disclosure about the Ayurvedic consultations, present and future, offered by Omar Czenstochouski. I understand the nature of the services to be provided. I understand that Omar Czenstochouski is NOT A LICENSED PHYSICIAN OR MEDICAL DOCTOR and that Ayurvedic services are NOT LICENSED by state. I understand it is my responsibility to maintain a relationship with my medical doctor. I have consented to use the services offered by Omar Czenstochouski.

CONSULTATION AGREEMENT AND LIABILITY WAIVER/RELEASE
CLIENT REQUEST & AUTHORIZATION
INFORMED CONSENT
******Please Read Carefully******

I_____, the undersigned, request and consent to an Ayurveda consultation/s offered by Omar Czenstochouski, Ayurvedic Practitioner, for the purposes of education and consultation. I understand that Omar Czenstochouski is NOT A LICENSED MEDICAL DOCTOR OR PHYSICIAN IN THE UNITED STATES OF AMERICA AND IS NOT LICENSED TO DIAGNOSE, TREAT OR CURE DISEASE OR MEDICAL CONDITIONS. ANY CONSULTATIONS WITH OMAR CZENSTOCHOUSKI ARE NOT A SUBSTITUTE FOR MEDICAL EXAMINATION, DIAGNOSIS AND TREATMENT FOR ANY DISEASE, MENTAL OR PHYSICAL.

Omar Czenstochouski may be able to help in my management of my health, and may recommend various things for me to consider in the management of my health and energy. Omar Czenstochouski may assist me in learning the differences between medical diseases and the balancing of life energy, which deals with health factors that are within my own control. I may elect to consult a physician prior to seeing Omar Czenstochouski, work with a physician concurrently with Omar Czenstochouski, or I may decide that my concern about medical conditions does not call for seeing a physician at this time.

I understand that I am seeking an educational experience rather than a personal diagnosis of any disease or malady. If this educational experience is being provided as part of a seminar on the teaching of the principles of Ayurvedic practice, it may involve an examination, an assessment/evaluation of me and a demonstration of how Ayurvedic practices would be used to make an evaluation. In this experience, I may learn of conditions which would be part of any Ayurvedic evaluation and may hear of the healing remedies that an Ayurvedic specialist or practitioner would use to evaluate these conditions. If I choose to use the ideas from the demonstration, I understand and acknowledge that is my choice to first present the ideas to a licensed health care provider and obtain his or her evaluation of the efficacy of the approach I wish to use.
I am aware that people may develop pathological conditions (i.e., illness, injury and/or disease) when natural resistance or immunities may be lowered as result of energy and health imbalances persisting for extended periods. However, I am aware that an energy or health imbalance does not necessarily create or reveal the existence of a medical condition. I am aware that recovery from an illness or injury may be facilitated by balancing vital energy, but I am also aware that there may be no way to assure that this effect may occur. I certify that I am not seeing Omar Czenstochouski for treatment of any physical infirmity or chronic ailment or injury, and that I am seeing Omar Czenstochouski to help manage and strengthen my general wellness and vital energy. Omar Czenstochouski does not recommend the discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner.

_____Initial

I acknowledge that I have voluntarily requested a consultation with Omar Czenstochouski. I understand that Omar Czenstochouski has studied Ayurveda for several years, has completed his 2.5 year Ayurvedic Wellness Practitioner Program with Kerala Ayurveda Academy and is enrolled to become a Doctor of Ayurveda with Kerala Ayurveda Academy. I also acknowledge that Omar Czenstochouski is not a board licensed medical doctor in the state of Florida.

I further understand that I am accepted for participation in this consultation and future consultations with Omar Czenstochouski based on the representations and agreements made by me and set forth below:

1. I understand that Ayurvedic medicine is currently unregulated in the United States of America. Thus, no license is required for an Ayurvedic practitioner/physician to practice.
2. I fully understand that the sole purpose of this Ayurvedic/Wellness consultation is for Omar Czenstochouski to assess the level of balance in my physiology per the principles of Ayurveda and to educate me on the Ayurvedic approach to enlivening the body's natural healing process and restore balance.
3. I also hereby request and consent to the recommended Ayurvedic dietary supplements, dietary changes and lifestyle changes including various modes of Ayurvedic therapies.
4. I understand that this consultation and ANY RECOMMENDATIONS ARE NOT A SUBSTITUTE FOR MEDICAL EXAMINATION, DIAGNOSIS AND TREATMENT FOR ANY DISEASE, MENTAL OR PHYSICAL.
5. I further understand that I will not modify or suspend any treatment program that I am currently undergoing without the knowledge and approval of my health care professional and/or specialist.
6. Ayurvedic dietary supplements have not been evaluated by the US FDA and are not intended to treat, cure, prevent or diagnose a disease. However, they have been used in India for over 5,000 years and are generally considered safe and effective.
7. I understand that any herbal food supplements recommended for me are not drugs. I understand that some herbal dietary supplements may interact with some allopathic medications and I will consult with my physician before taking any herbal food supplements.
8. I further understand that as with drugs, vitamin and mineral supplements, Ayurvedic dietary supplements may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications, or may show symptoms due to certain pre-existing disease conditions. I do not expect Omar Czenstochouski to able to anticipate and explain all risks and complications; I wish to rely on Omar Czenstochouski to exercise judgement in recommending the dietary supplements that he determines are in my best interest based on facts known.
9. I understand that my health and my healing process require my active participation and are my own personal responsibility.

In consideration of my consultation with Omar Czenstochouski I agree that I (or my heirs, guardians, legal representatives and assigns) will not make a claim or file and action against Omar Czenstochouski for injury or damage resulting from negligence or other acts howsoever caused in connection with my consultation with Omar Czenstochouski or for claims or actions make or brought on behalf of me or my child in connection with Omar Czenstochouski.

In addition, I hereby waive, release and discharge Omar Czenstochouski from all actions, claims or demands that I, my heirs, guardians, legal representatives or assigns, now have, or may hereafter have for injury or damages resulting from my participation in my consultations with Omar Czenstochouski.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A WAIVER AND RELEASE OF POTENTIAL LIABILITY AND A CONTRACT BETWEEN ME AND OMAR CZENSTOCHOUSKI, AND I SIGN OF MY OWN FREE WILL.

I have read, or had read to me, the above consent. By signing below, I agree to the Ayurvedic consultation given to me by Omar Czenstochouski. I intend for this consent form to cover the entire course of consultations for my present imbalance and for any future conditions(s) for which I seek Ayurvedic council and wellness. I hereby release Omar Czenstochouski from all liabilities whole and in part that may arise from this consultation and future consultations.

Signature of Client:_____ Date:_____

Print Name of Client:_____ Phone:_____

Address: _____ Email: _____

Signature of Parent or Legal Guardian (If client is under 18yrs of age): _____

Signature of Omar Czenstochouski: _____ Date_____

Policies
Consultation with Omar Czenstochouski is an educational wellness service that provides education through consultation to individuals regarding holistic wellbeing. Implementation of any educational material is 100% the decision of the individual. Omar Czenstochouski implies no guarantees and makes no claims. Omar Czenstochouski consults and educates the individual on how they may personally take responsibility for their own health if they so choose. Adherence to any consultation or education is 100% the responsibility of the individual. Omar Czenstochouski does not diagnose or treat disease.

Health Disclaimer
All health and health related information discussed within the Ayurvedic consultation is intended to be general in nature and should not be used as a substitute for medical treatment. The individual is 100% responsible for communicating with all parties involved including their own family practitioner.

Missed appointment policy
A 24-hour notice is required for any rescheduled appointments. Phone, email and in-person are acceptable methods of rescheduling or cancelation. Facebook, or any other form of communication is not acceptable for appointment management.
No-shows and cancellations with less than one day's notice are a significant problem for our personal/intimate practice. We feel that charging $50 for no-shows is the best fit for out practice. We are respectful of our clients and their scheduled time with us and we appreciate your reciprocation in this matter.

_____Initial

By signing below, I acknowledge that I have read and understand the policies, health disclaimer and missed appointment policy. I also understand my responsibilities as a client of Omar Czenstochouski and hereby release Omar Czenstochouski and associates from any responsibility due to my own personal action and/or inaction.

Signature of Client :_____

Print Name of Client: _____ Date:_____

Signature of Parent or Legal Guardian (If client is under 18yrs of age): _____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: October 1st 2021

We keep health records of the wellness services we provide for you. You may ask to see and copy your records. You may ask to correct your records. Your records will be kept confidential unless you give us written permission to release them or we are required to do so by law.

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of consultations, payment and health technique operations in this office. You may see your records or get more information about them by contacting our office.

For more information about our privacy practices please inquire with us.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Client or legal representative Date