

# Ayurveda Client Consent Form

Name: (Please Print) \_\_\_\_\_

Phone (home): \_\_\_\_\_ Cell phone or evening: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email (optional): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Current Medications and dosage: \_\_\_\_\_

\_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

If yes, physician's name: \_\_\_\_\_

Have you ever had an Ayurvedic Consultation before?  Yes  No

If yes, when was your last session? \_\_\_\_\_

Do you have a particular area of concern? \_\_\_\_\_

\_\_\_\_\_

I understand that Ayurveda is an ancient system of alternative medicine that is used for following healthy lifestyle in terms of food, exercise and sleep. I understand that Ayurvedic practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. I understand that Ayurvedic treatment does not take the place of medical care. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological ailment I may have. I understand that Ayurveda can complement any medical or psychological care I may be receiving.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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Privacy Notice: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.

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