Swami Paramhansa

Swastha Siksha Avam Paryavaran Sanrakshana Samsthana

(under section 44 of MPR act. 1973. 05/26/01/0897/10.Govt. of India)

PARAMHANSA HOLISTIC HEALTH HOME

(An offering from Swami Paramhansa Samsthana)

IP No:…… Name: ……

Age:……Gender: ……

Section/Department:……

Yoga/Ayurveda/Naturopathy/Allopathic Consultant: ……

……

Doctor incharge……

Therapist: ……

Counselor: ……

SWAMI PARAMHANSA SWASTHA SIKSHA AVAM PARYAVARAN SANRAKSHANA SAMSTHANA

(Under section 44 of MPR act 1973, 05/26/01/0897/10. Govt of India)

Paramhansa Vatika #84, Area Rampur, Circle - Raghurajnagar, Satna (M.P.).

Email : info@paramhansa.org

Web: www.paramhansa.org

PARAMHANSA HOLISTIC HEALTH HOME

Health & Registration Information Form

Name: ..... Age .....

Education: ..... Occupation: .....

Gender: ..... Date of Birth: ..... Place: ..... Time: .....

Address: .....

.....

..... Postal Code: .....

Phone: ..... Email: .....

Have you taken Yoga or Ayurveda or Other Complementary and Alternative medicines before?

.....

The main things I hope to gain from my classes are: .....

Class/Consultation/Therapy requested:.....

Do you have any medical/psychological ailments shown below?

Allergy ☐	COPD ☐	Knee Injuries ☐
Anemia ☐	Depression ☐	Low Blood Pressure ☐
Anxiety/Mood Disorders ☐	Diabetes ☐	Neck Issues ☐
Any addictions ☐	Dizziness ☐	Obesity ☐
Any fractures ☐	Eye/Ear Problems ☐	Osteoporosis Pain ☐
Any Infections ☐	Fibromyalgia ☐	Pregnancy ☐
Arm/Shoulder Injuries ☐	Gastritis ☐	Recent Operations ☐
Arthritis ☐	Heart Problems ☐	Sciatica ☐
Asthma ☐	Hernia ☐	Thyroid Disorders ☐
Back Problems ☐	High Blood Pressure ☐	Wrist Problems ☐
Bronchitis ☐	High cholesterol ☐	(Carpal Tunnel) ☐
Cancer ☐	IBS ☐	

Any other :

.....

(All information is strictly confidential)

It is my responsibility to ask for clarifications on anything that I do not understand. I will not put my body in any position that does not feel comfortable. If I feel any pain I will stop immediately. I understand this class is for me to develop an awareness of my body and will learn to heed the messages it sends me. I agree to waive claims against any persons connected with practice for any injuries I may sustain and assume full responsibility for all my actions related to practice.

I understand and agree to the conditions set out above. Above information is correct and complete to the best of my knowledge.

PARAMHANSA HOLISTIC HEALTH HOME

OP/IP No.

Health & Registration Information Form

Name: ..... **Age/**

Gender:.....

Chief Complaints :

HOPI:

Personal History : Appetite: .....

Sleep: .....

Bowels: .....

Bladder: .....

Smoking/ Alcohol: .....

Menstrual/ OBG History :

Past History :

Family History :

Treatment History :

Social/ Stress History:

GENERAL PHYSICAL EXAMINATION:

Pallor:

Icterus:

Cyanosis:

Clubbing:

Lymphadenopathy:

Edema:

Vital Signs:

PR:

BP:

RR:

Temperature:

Height/ Weight:

BMI:

SYSTEMIC EXAMINATION:

CVS:

RS:

P/A: CNS: Musculo Skeletal

System:

INVESTIGATIONS AVAILABLE:

PROBABLE DIAGNOSIS:

FINAL DIAGNOSIS:

DATE

TREATMENT PLAN:

Diet:

Counseling:

Physiotherapy:

Acupressure:

Ayurveda:

Yoga Therapy:

OP/IP No.

DATE
SIGN

DOCTORS NOTES