CIANN MASI

Ayurveda/Naturopathy/Intuitive Medicine

CONFIDENTIAL CLIENT HISTORY

Child's Name: _____

Parent's Name: _____

Address:_____

City, State, Zip:_____

Telephone/cell: _____ E-mail: _____

Birth date: _____ Birth place: _____ Age: _____

Blood type: _____ Height: _____ Weight: _____

Social Security Number: _____ Credit Card Number: _____

How did you hear about our practice?: _____

Who may we thank for referring you? _____

FINANCIAL POLICY AGREEMENT

-There is a $555.00 charge for each initial consultation.
-There is a $195.00 charge for each follow-up visit.
-Visits may be paid in Cash, Check or pre-paid via Credit Card only.
-Your customized program often incorporates herbal formulas. There is an additional charge for herbal formula design, preparation, and shipping.
-Our office does not bill insurance companies. A superbill may be provided for reimbursement.
-Payments are due when appointments are scheduled.
-All appointment cancellations require a 48 hours notice.
-If you cancel your scheduled visit without a 48 hour notice or do not show to your appointment, the full amount of your scheduled visit will be billed to your account.
-I have read and understood all financial policies.

Parent's Signature: _____Date: _____

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Los Angeles - London
+1 949.344.0433

LIFE IN BALANCE

Welcome to the integrative practice of Ciann Masi! My mission is to help you achieve a deeper sense of balance and well-being by addressing your unique needs and constitution. Through our work together, I aim to enhance your self-awareness and support your natural ability to maintain health. My goal is to empower you with the tools and knowledge needed to make choices that foster a harmonious and fulfilling life. I'm here to guide you toward greater balance and a richer appreciation of everyday moments.

Outline of Services

Initial Consultation:

In-Depth Assessment: I will review your physical, mental, energy, and sensory routines, assess your core balance, and identify areas where you might benefit from adjustment.

Introduction to Your Personalized Approach: You will learn how your unique constitution influences your health and discover the principles that will guide your journey.

Tailored Plan: Together, we will develop a personalized plan that may include meditation, yoga, dietary adjustments, and breathing exercises, all tailored to support your specific needs.

Ongoing Support:

Regular Check-Ins: I will offer follow-up sessions to monitor your progress, provide support, and adjust your plan as needed.

Continuous Guidance: I will provide ongoing advice to help you integrate new practices into your daily routine and adapt to any changes along the way.

Understanding the Process

My approach is centered on creating and maintaining balance by addressing your unique needs and adapting to life's changes. While you may see some immediate benefits, achieving lasting balance and well-being is a gradual process. I understand that life is dynamic, so the program encourages ongoing adjustments based on seasonal changes, emotional shifts, and other factors.

This process requires your active involvement and commitment. While I will offer guidance and support, your dedication to incorporating these practices into your daily life is essential. Small, consistent changes can lead to significant improvements in your overall health and well-being.

I look forward to supporting you on this journey, helping you achieve a balanced and fulfilling life with enhanced well-being and a renewed sense of self.

Do you consent to your child receiving Ayurvedic therapy, nutritional or health support?

Parent's Signature: _____ Date_____

Office: _____Date_____

INFORMED CONSENT

Informed Consent to Receive Ayurvedic Health Care through Ciann Masi:

All clients participating in alternative health care should be advised of the following:

The goal of all programs is to create within your body and mind an optimal environment for healing and to enhance your body's natural ability to heal itself through the principles of Ayurveda and Intuitive Medicine. My mission is to empower and educate individuals to take charge of their own health, fostering a state of energy, joy, and appreciation for life.

I, _____, hereby agree to the following:

Participation Acknowledgment: I am participating in alternative health programs, yoga classes, or workshops offered by Ciann Masi. During these sessions, I will receive information and instruction about alternative health, nutrition, and/or yoga. I acknowledge that yoga and related activities require physical exertion that may be strenuous and could cause physical injury. I am fully aware of the risks and hazards involved.

Medical Responsibility: I understand it is my responsibility to consult with a physician prior to and regarding my participation in any alternative healthcare programs, yoga classes, or workshops. I represent and warrant that I am physically fit and have no medical conditions that would prevent my full participation in these activities.

Assumption of Risk: In consideration of being permitted to participate in these programs, I agree to assume full responsibility for any risks, injuries, or damages, known or unknown, which I might incur as a result of my participation.

Waiver of Claims: In further consideration of being allowed to participate, I knowingly, voluntarily, and expressly waive any claims I may have against Ciann Masi for any injury or damages sustained as a result of my participation in the programs.

Release of Liability: I, my heirs, or legal representatives, forever release, waive, discharge, and covenant not to sue Ciann Masi for any injury, physical or emotional harm, or death caused by negligence or any other act.

No Medical Diagnosis: Ciann Masi is not trained in Western diagnosis or treatment and will not suggest alterations to my medical care.

No Medical Doctor: Ciann Masi is not a Medical Doctor (M.D.).

Ayurveda Legal Status: In the United States, Ayurveda is a non-licensed profession. Its practice was formally legalized under Senate Bill 577 in January 2003. I state that I come to Ciann Masi with the intent of seeking information and not with the purpose of entrapment. If I am a member of any medical or regulatory agency, I will identify myself as such before the appointment begins.

Referral for Medical Evaluation: If I am suffering from a disease or symptom that has not been evaluated by a Medical Doctor or other licensed health care professional, I am advised to seek proper evaluation and may be provided with a referral form. If referred to a Medical Doctor, I will either go for evaluation or sign an acknowledgment that such a referral was recommended.

Medication and Prescriptions: Ciann Masi will not alter any of my prescriptions without the approval of my Medical Doctor. Recommendations may be made to consult my Doctor about reducing medication if deemed appropriate.

Holistic Evaluation: Although Ciann Masi may take my blood pressure and vital signs and perform examination techniques similar to a routine medical examination, these evaluations are conducted from an Ayurvedic or holistic perspective and do not replace a medical evaluation. If any findings suggest a possible medical imbalance, I will be referred to a Medical Doctor for further evaluation.

Arbitration Agreement: I agree that any disputes or claims arising from my participation in the programs will be resolved through binding arbitration in accordance with the rules of the American Arbitration Association. I understand that this agreement to arbitrate waives my right to a trial by jury.

I have read the above informed consent and release of liability. I fully understand its contents and voluntarily agree to the terms and conditions stated above.

Parent's Signature: _____

Date: _____

Practitioner's Signature: _____

Date: _____

Family Background

Describe your family structure (e.g., siblings, parents, extended family):

Are there any recent or significant changes in the family (e.g., divorce, new sibling, relocation)?

What is the family's current living situation (e.g., single-parent, two-parent household, shared custody)?

Medical and Developmental History

Has your child had any significant medical conditions or developmental issues (e.g., chronic illnesses, developmental delays)?

Is your child currently taking any medications? If so, please list them:

Has your child had any previous therapy or counseling? If so, what was the focus and outcome?

Are there any allergies or dietary restrictions?

Has your child had any recent hospitalizations or surgeries?

Current Concerns

What are the primary reasons you are seeking therapy or health support for your child?

Describe any specific behavioral, emotional, or psychological issues your child is experiencing:

How long have these issues been occurring?

Have there been any recent events or changes that might have affected your child (e.g., trauma, loss, family changes)?

Behavior and Emotions

How does your child typically express their emotions (e.g., verbally, behaviorally)?

Are there particular situations or triggers that seem to affect your child's mood or behavior?

How does your child get along with peers and adults?

Does your child have any particular fears, anxieties, or phobias?

Does your child have any noticeable changes in sleep patterns or appetite?

School and Social Life

How is your child performing academically and socially at school?

Does your child have any difficulties with schoolwork, concentration, or social interactions?

What are your child's interests or hobbies?

How does your child typically spend their free time?

Family Dynamics and Parenting

What are your goals for your child's therapy or health support?

Are there any parenting strategies or approaches that have been effective or ineffective with your child?

How do family members typically handle conflicts or stress?

Are there specific family dynamics or issues that you believe impact your child's well-being?

Support System

Does your child have a support system outside of the family (e.g., friends, teachers, mentors)?

Are there any community resources or activities your child is involved in?

Additional Information

Is there anything else you think is important for the therapist or healthcare provider to know about your child?

Do you have any concerns or questions about Ayurvedic therapy or the Ayurvedic health support process?

Are there any specific goals or expectations you have for your child's session?

Consent and Acknowledgment

Do you agree to provide any additional information as needed during the therapy or health support process?

Parent's signature_____Date:_____

Office _____Date:_____

Do you consent to your child receiving Ayurvedic therapy, nutritional or health support?

Parent's Signature: _____Date_____

Office: _____Date_____

CHIEF HEALTH CONCERNS

What are your main health concerns at this time? Order by importance to client.

PRIMARY CONCERNS	OFFICE NOTES

PLEASE INCLUDE MAJOR CONDITIONS, DATES OF TREATMENT, AND PROCEDURES PERFORMED.

Serious illnesses: _____

_____

Hospitalizations: _____

Operations: _____

List other pertinent past conditions: _____

_____

Has your child been under the care of a licensed health care professional in the past year? ❑**Yes** ❑**No**
If so, for what reasons: _____

Is there any possibility that your child is pregnant? ❑ Y ❑ N

FAMILY HISTORY PLEASE CHECK THE APPROPRIATE BOXES AND INDICATE FAMILY MEMBER.

❑ Cancer	❑ Diabetes
❑ High Blood Pressure	❑ Heart Disease
❑ Stroke	❑ Mental Disorder
❑ Other (explain)	❑ Other (explain)

CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS (CHILD)

What medications, herbs, supplements is your child currently taking?
Please include significant remedies that you have recently stopped taking.

Name of substance:____________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

Who recommended/prescribed? ____________________
Purpose of substance: ____________________
How long have you been taking it: ____________________
In what form do you take it (include dosage): ____________________
How often do you take it? ____________________
What effects have you noticed? ____________________

Name of substance:____________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

Who recommended/prescribed? ____________________
Purpose of substance: ____________________
How long have you been taking it: ____________________
In what form do you take it (include dosage): ____________________
How often do you take it? ____________________
What effects have you noticed? ____________________

Name of substance:____________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

Who recommended/prescribed? ____________________
Purpose of substance: ____________________
How long have you been taking it: ____________________
In what form do you take it (include dosage): ____________________
How often do you take it? ____________________
What effects have you noticed? ____________________

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DAILY ROUTINES (CHILD)

DAILY SCHEDULE (please include approximate times)

Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities)

	Time	*Activities*	
Morning			*VARIATIONS*
Awaken			
Breakfast			
Activities			
Mid-day			
Lunch			
Activities			
Homework			
Evening			
Supper			
Activities			
Night			
Activities			
Bed-time			

List regular practices that are not included in the above schedule, e.g., exercise, meditation, spiritual practices, etc.

Is your child sexually active? Y ❑ N ❑ Frequency? _____

Other comments about daily routines: _____

FOODS

What types of food(s) are eaten on a regular basis?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

Are there any routines around eating:

Any current or past issues with chronic disordered eating or other food related issues? ❑ Y ❑ N

ALLERGIES OR SENSITIVITIES (CHILD HISTORY)

Does your child have allergic reactions to any substances? If yes, please list.

GENERAL HEALTH HABITS

How many cups of caffeinated beverages does your child drink per day? # _____

Type(s) of beverage: coffee/tea/soda _____

How many cups of non-caffeinated beverages per day? # _____

Type(s) of beverage: herbal tea/milk/juice/other _____

How much water does your child drink per day?
_____

Does your child exercise regularly? Y N

Length of time: _____

Times per week: _____

Type(s) of exercise: _____

Does your child smoke? _____, How many cigarettes per day? _____

Does your child drink alcohol, how many glasses of alcohol per week? (Include beer, wine, liqueurs and hard liquor) _____ per week. Type(s) of beverage:_____

Any current or past problems with addiction or substance abuse? Y N
Substance: _____ Amount: _____ When quit? _____

Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite): _____

_____

Body temperature: Does your child generally run warm or cold? Please explain:

REVIEW OF SYMPTOMS (CHILD)

Check all symptoms that are of concern to you at this time that you would like to discuss today. Please indicate any area in which you have experienced a severe episode and indicate if the episode was in the previous (6) months or prior to (6) months time.

HEAD

Concern	Office	
		Headaches
		Dizziness
		Fainting spells
		Loss of balance
		Difficulty remembering
		Difficulty thinking clearly
		Thinning or loss of hair

EARS

Concern	Office	
		Hearing loss
		Ringing
		Earaches–Pain
		Discharges
		Bleeding

EYES

Concern	Office	
		Pain–soreness in eyes
		Redness
		Burning
		Mucous
		Dryness
		Itching
		Tic/twitch
		Blurred/loss of vision

MOUTH

Concern	Office	
		Excessive thirst
		Loss of taste
		Strange taste
		Bad breath
		Lip ulcers or lesions
		Dry/cracking lips
		Tongue pain
		Bleeding gums
		Receding gums
		Tooth pain
		TMJ

NECK

Concern	Office	
		Pain
		Swollen glands
		Lumps
		Stiffness

CHEST

Concern	Office	
		Pain in chest
		Tightness/pressure in chest
		Heart palpitations
		Shortness of breath
		Painful–difficult breathing

		Persistent cough
		Frequent chest colds

Concern	Office	NOSE
		Loss of smell
		Bleeding
		Pain
		Discharge
		Post-nasal drip
		Sinus Congestion

Concern	Office	SKIN
		Dry–flakey
		Rashes
		Blisters
		Acne
		Changing or bleeding moles
		Response to insect bites

Concern	Office	DIGESTION
		Pain
		Burning indigestion
		Belching
		Regurgitation
		Vomiting
		Excessive Gas
		Heavy–Bloaty after eating
		Hemorrhoids
		Constipation (< 1 BM/ day)
		Diarrhea
		Both constipation & diarrhea
		Bloody Stool

Concern	Office	CIRCULATION
		Varicose veins
		Cold hands–feet
		Swollen ankles
		Calf pain
		Puffy eyes

Concern	Office	FEMALE SYSTEM
		Irregular cycle
		Heavy/prolonged bleeding
		Missed menses
		Painful menses
		Spotting
		Discharge
		PMS symptoms
		Pregnant

Concern	Office	URINARY
		Loss of urination control

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		Painful urination
		Urine retention, dribbling
		Daytime urination often
		Nighttime urination often
		Blood in urine
		Pain in kidney/groin area
		Kidney/bladder infections

Concern	Office	MUSCLES&JOINTS
		Swelling in joints
		Pain/ache in joints
		Stiff joints
		Persistent muscle/ bone pains
		Tremors/tics in muscles
		Muscle weakness/ atrophy

Concern	Office	NERVES
		Loss of taste, smell or touch
		Tingling sensations
		Tremors in limbs
		Uncoordinated muscle/ limbs

		Miscarriage
		Infertility
		Genital sores
		Ovarian cyst
		Fibroids

Concern	Office	BREASTS
		Swelling
		Redness
		Lumps
		Nipple discharge
		Tenderness–pain

Concern	Office	MALE SYSTEM
		Prostate gland swollen/ painful
		Low sperm count
		Low motility
		Genital sores or lesions
		Genital discharge
		Erection difficulty