



Jivaka Ayurveda

Rob Talbert, C.A.S.
Clinical Ayurvedic Specialist
949•497•3134

Holistic Health & Longevity through The Science of Life

Welcome,

Thank you for considering Jivaka Ayurveda for your holistic health care needs. In preparation for your consultation, we are enclosing a consultation Intake Packet for you to review, complete and return to Jivaka Ayurveda. The packet contains information about the Consultation Service and includes several forms that will help us prepare for your visit.

The Consultation Intake Packet includes:

- A Brief Introduction to Ayurveda (1 page)
- Health Information And History, Financial Policy Agreement (11 pages)
- Informed Consent (1 page)
- Directions (1 page)

Before you complete the forms please look over the entire packet to familiarize yourself with what will be asked. Then complete all forms as thoroughly as you can. Return them to Jivaka Ayurveda so that they arrive at least 24 hours prior to your appointment date. Please keep this cover letter, the brief Introduction to Ayurveda and the directions for your records.

- Date your packet is due back at Jivaka Ayurveda: _____
- Initial Consultation appointment (2 hrs, \$190) Date: _____ Time: _____
- Report of Findings appointment (1 hr, \$95) Date: _____ Time: _____

Please return your forms to:

Jivaka Ayurveda
481 Osgood Court
Laguna Beach, CA 92651

We appreciate your taking the time to provide the information requested, and look forward to welcoming you for your consultation at Jivaka Ayurveda.

Sincerely,

Rob Talbert

A Brief Introduction to Ayurveda

Ayurveda means “Science of Life”. It is an ancient system of healing that focuses on the complete person which, includes the body, mind and spirit. Traditional medicine tends to focus on a specific symptom or disease. Ayurveda says that for complete wellness to occur, the body, mind and spirit must be in harmony with each other and naturally resistant to disease causing conditions.

Ayurveda defines wellness not as “the absence of defined disease” but when all bodily tissues, organs, systems and functions are acting together in a healthy way and are able to maintain health and wellness in spite of potential illness causing influences. Ayurveda believes that by balancing the various mind-body functions the natural intelligence of the body will automatically bring itself to wellness.

Ayurveda uses natural processes and methods whenever possible for bringing wellness and restoring good health. Traditional medicine usually attempts to restore health by treating the symptoms of the body or by attacking the disease, and usually uses artificial drugs and medicines to treat these symptoms and diseases. Ayurveda is complimentary to traditional medical practices and does not replace medical diagnosis and treatment.

Ayurveda recognizes that each person has a unique mind-body constitution. Ayurveda then identifies the various components of that individual's constitution, determines where imbalances and disturbances exist, and provides education, guidance and a plan for helping the individual bring about their own improvements in health and wellness.

Ayurvedic practices focus on clearing disturbances and balancing metabolic and energetic patterns that support constitutional resilience. It is the individual's implementation of the right Ayurvedic practices that brings about balance and wellness. People are more vulnerable to developing pathological illness or disease when vital energies of the mind, body and spirit are disrupted. Ayurveda can assist in learning how to improve health through improved lifestyle functions.

The National Institute of Health Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003. Ayurvedic consultations are considered alternative or complementary to healing arts that are licensed by the State of California.

Jivaka Ayurveda works with clients through a collaborative planning process. Collaborative planning is a process for developing an understanding between you and Jivaka Ayurveda for specific services including,

- What Jivaka Ayurveda can do to contribute toward the achievement of your health and wellness objectives.
- What you the client can do to contribute toward the achievement of your health and wellness objectives.
- How we can cooperate together to facilitate your plan for your health and wellness.

CONFIDENTIAL CLIENT HISTORY

Name: _____

Address: _____

City, State, Zip: _____

Telephone – Home: _____ Work: _____ Cell: _____

Email: _____ Birth date: _____ Age: _____

Partner status: _____ # of children: _____ Ages: _____ Occupation: _____

Referred by: _____

Family Physician: _____

OBJECTIVES

1. Please check the items that reflect your main objectives:

- I want an alternative approach to allopathic medicine for managing illness and disease
- I want to improve my general health and wellness and reduce my vulnerability to illness and disease
- I want to improve my lifestyle and dietary practices to improve my health
- I want to change my habits and behavioral patterns to improve my relationships with others
- I want to manage stress, tension and worry to attain a more stable emotional nature.

2. What do you want to achieve or change in terms of your health and wellness? _____

3. How would your life be different if you were to achieve these objectives to your satisfaction?

REVIEW OF CURRENT CONCERNS

4. What are the major concerns that have brought you to this office today? _____

5. When did this begin? _____

6. Has anything recently changed or become worse? _____

7. Have you had a diagnosis? If so, what was it, how was it arrived at, and by whom? _____

8. Are you currently receiving care from any other health professional?

(Name) _____

For what condition(s)? _____

9. Have you been under the care of a licensed health care practitioner in the past year? Yes No

If so, for what reasons: _____

Date of last physical exam: _____

10. Do you see a chiropractor, massage therapist or acupuncturist? Yes No

Name : _____

11. Other Significant Symptoms:

12. Other Diagnosed conditions and date diagnosed _____

PAST HEALTH CONDITIONS

13. Serious illnesses/ dates: _____

14. Hospitalizations/ dates: _____

15. Operations/ dates: _____

16. Other conditions/ dates: _____

17. Do you have any infectious diseases that you know of? Yes No

If yes, please list them: _____

18. Height _____ Current weight _____ Desired weight _____

19. Weight 1 month ago _____ Weight 1 year ago _____

CURRENT HEALTH CONCERNS

Please indicate any physical and emotional patterns that you have had **in the last 3 month**.

Next to each please assigning a

Frequency (with a letter)

C = Constant

D = Several times a day

W = Several times a week

M = Several times a month

and an

Intensity (with a number 1 to 10).

1 to 3 = mild discomfort

4 to 7 = moderate discomfort

8 to 10 = severe discomfort

Please read these instructions carefully.

If it is a diagnosis condition please list the date of diagnosis.

Digestion

	F	I
Abdominal Pain		
Excessive Gas		
Belching		
Bloating		
Food cravings		
Food allergies		
Poor appetite		

	F	I
Burning Indigestion		
Heartburn		
Acid reflux		
Smelly gas		
Ulcers		
Intestinal Bleeding		

	F	I
Nausea		
Vomiting		
Difficulty swallowing		
Sluggish after eating		
Sleepy after eating		
Feeling full after eating very little		

Elimination

Constipation <1bm/day		
Alternating constipation & diarrhea		
Rectal Pain		
Food particles in stool		
Unexplained changes in bowel habits		

Diarrhea		
Loose stools		
Bloody stool		
Black stools		
Unusual color to stool		
Hemorrhoids		

Mucus in stool		
Pass stool only after meal		

Neuropsychology

Worry		
Anxiety		
Fear		
Overwhelm		
Spacey feeling		
Insomnia		
Indecisive		
Seizures		
Loss of balance		
Poor memory		
Headaches		
Migraine		
New or more severe headaches		
Panic Attacks		

Irritable		
Anger		
Rage		
Resentment		
Jealousy		
Envy		
Critical of other		
Critical of self		
Intense		
Sharp		

Lethargy		
Sadness		
Depression		
Greediness		
Over attachment		
Grief		
Procrastination		
Foggy feeling		
Numbness		
Poor mental clarity		
Lack of coordination		
Difficulty concentrating		
Mental status changes		

Dry skin		
Itching		
Rashes		
Hives		
Bruise easily		
Change in skin texture		

Skin and Hair

Poor healing sores		
Eczema		
Psoriasis		
Dandruff		
Hair Loss		

Pimples		
Moles		
Excessive sweating		

Poor hearing		
Earaches		

Ears

Ear Pain		
Ringing in ears		

Ear infections		
Dizziness		

Dry eyes		
Poor vision		
Blurred vision		
Spots in front of eyes		
Eye pain		

Eyes

Red eyes		
Nearsightness (myopia)		
Farsightness (hyperopia)		
Astigmatism		
Flashes of Light		

Eye mucous		
Cataracts		
Glaucoma		
Eye Surgery		

Head, Nose and Throat

Jaw pops, clicks or locks		
Grinding teeth		
Dental Complications		
Bad breath		
Sore throat		

Mucous in throat		
Chronic throat clearing		
Frequent colds		
Canker sores		
Nose bleeds		

Facial pain		
Swollen glands		
Sinus congestion		
Cold sores		

Low blood pressure		
Fainting		
Irregular heart beat		
Palpitations		
Cold hands		
Cold feet		
Anemia		
Intolerance to heat/cold		

Cardiovascular

High blood pressure		
Chest Pain		
Angina		
Heart Attack		
Heart Murmur		

High Cholesterol		
Heart Disease		
Heart Surgery		

Prolonged Bleeding When Cut
Stroke, CerebroVascular Accident

Dry Cough		
Brown or gray phlegm		
Pain on breathing		
Tuberculosis		
Shortness of breath without exertion		

Respiratory

Coughing blood		
Yellow or green phlegm		
Bronchitis		
Pneumonia		
Difficulty breathing when lying down		

Moist cough		
White phlegm		
Asthma		

Painful urination	<table border="1"><tr><td></td><td></td></tr></table>			Urinary	Blood in urine	<table border="1"><tr><td></td><td></td></tr></table>			Kidney stones	<table border="1"><tr><td></td><td></td></tr></table>		
Urinary urgency	<table border="1"><tr><td></td><td></td></tr></table>				Kidney Disease	<table border="1"><tr><td></td><td></td></tr></table>			Decreased flow	<table border="1"><tr><td></td><td></td></tr></table>		
Incontinence	<table border="1"><tr><td></td><td></td></tr></table>				Bladder Disease	<table border="1"><tr><td></td><td></td></tr></table>			Kidney infections	<table border="1"><tr><td></td><td></td></tr></table>		
Frequent urination	<table border="1"><tr><td></td><td></td></tr></table>				Slow to start	<table border="1"><tr><td></td><td></td></tr></table>			Bladder infections	<table border="1"><tr><td></td><td></td></tr></table>		
Inability to hold urine	<table border="1"><tr><td></td><td></td></tr></table>				Difficulty starting	<table border="1"><tr><td></td><td></td></tr></table>				<table border="1"><tr><td></td><td></td></tr></table>		
Irregular flow	<table border="1"><tr><td></td><td></td></tr></table>				Difficulty stopping	<table border="1"><tr><td></td><td></td></tr></table>				<table border="1"><tr><td></td><td></td></tr></table>		

	Musculoskeletal										
Neck pain	<table border="1"><tr><td></td><td></td></tr></table>			Muscle pain	<table border="1"><tr><td></td><td></td></tr></table>			Stiffness	<table border="1"><tr><td></td><td></td></tr></table>		
Back pain	<table border="1"><tr><td></td><td></td></tr></table>			Muscle weakness	<table border="1"><tr><td></td><td></td></tr></table>			Reduced range motion	<table border="1"><tr><td></td><td></td></tr></table>		
Aches and pains	<table border="1"><tr><td></td><td></td></tr></table>			Hot, red or swollen joint	<table border="1"><tr><td></td><td></td></tr></table>				<table border="1"><tr><td></td><td></td></tr></table>		

	Male Reproductive										
Difficulty with erection	<table border="1"><tr><td></td><td></td></tr></table>			Burning with urination	<table border="1"><tr><td></td><td></td></tr></table>			Testicle swelling	<table border="1"><tr><td></td><td></td></tr></table>		
Difficulty with ejaculation	<table border="1"><tr><td></td><td></td></tr></table>			Prostate infection	<table border="1"><tr><td></td><td></td></tr></table>			Testicle pain	<table border="1"><tr><td></td><td></td></tr></table>		
Problems emptying your bladder completely	<table border="1"><tr><td></td><td></td></tr></table>			Force of your urination decreased	<table border="1"><tr><td></td><td></td></tr></table>			Discharge from penis	<table border="1"><tr><td></td><td></td></tr></table>		
					<table border="1"><tr><td></td><td></td></tr></table>						

Do you usually get up to urinate during the night? Yes No Number of times: _____
 Have you had a prostate and rectal exam? Yes No
 If yes, date of last prostate and rectal exam? ____/____/_____

Other concerns: _____

	Female Reproductive										
Irregular cycles	<table border="1"><tr><td></td><td></td></tr></table>			Cramps	<table border="1"><tr><td></td><td></td></tr></table>			Heavy bleeding	<table border="1"><tr><td></td><td></td></tr></table>		
Pain with intercourse	<table border="1"><tr><td></td><td></td></tr></table>			Discharges	<table border="1"><tr><td></td><td></td></tr></table>			Breast lumps	<table border="1"><tr><td></td><td></td></tr></table>		
Unusual bleeding	<table border="1"><tr><td></td><td></td></tr></table>			Hot flashes	<table border="1"><tr><td></td><td></td></tr></table>			Clots	<table border="1"><tr><td></td><td></td></tr></table>		
Vaginal Dryness	<table border="1"><tr><td></td><td></td></tr></table>						<table border="1"><tr><td></td><td></td></tr></table>				

Is there a possibility that you are pregnant? Yes No Possible How many months? ____

Are you nursing? Yes No

Age at first menses: _____
 Date of last pap smear ____/____/_____ Result _____

Are you on Birth Control? Yes No Type : _____

Do you keep track of your menses on a calendar Yes No
 # of pregnancies _____ Abortions _____ Premature births _____
 # of Miscarriages _____ # of births _____

Onset of menopause ____/____/_____ Are you taking HRT? Yes No
 Have you had a hysterectomy? Yes No Date: ____/____/_____

Describe your menstrual pattern. If menopausal, describe patterns when still menstruating.

Regularity: irregular, variable regular

Quantity of flow: variable, light, moderate, heavy

Level of discomfort: painful, moderate, painless

Length of cycle: _____# of days (e.g. 28 days)

Duration of flow/bleeding: _____# of days (e.g. 3-5)

Describe any gynecological problems?

	General	
Osteoarthritis	Fevers	Diabetes
Rheumatoid arthritis	Persistent Fever	Slow metabolism
Other arthritis	Night sweats	Thyroid Disease
Changes in weight	Rheumatic Fever	Thyroid Medication
Cancer	HIV Exposure	Venereal Diseases
Chemotherapy	Jaundice	Serious injuries
Radiation	Gallstone	Trauma
Chills	Implant	Inguinal hernia
Epilepsy	Prosthesis	Umbilical hernia
Convulsions	Cosmetic surgery	Other hernia
Seizures		
Excessive thirst	Hepatitis A	
Fatigue	Hepatitis B	
	Hepatitis Non-A Non-B	
Sudden energy drop		
Mental disorder	Short-term loss of vision, speaking or movement control	
Mononucleosis	Feet or Ankles Swelling	
	Troubles lifestyle conditions	

GENERAL HEALTH AND LIFESTYLE PATTERNS

20. Do you exercise regularly? Yes No Length of time: _____ Times per week: _____

Type(s) of exercise: _____

21. How much of the following do you drink?: (Indicate number of 8 ounce cups per day)

- | | | |
|---|--|--|
| <input type="checkbox"/> Plain water: _____ | <input type="checkbox"/> Caffeinated Coffee: _____ | <input type="checkbox"/> Decaf coffee: _____ |
| <input type="checkbox"/> Herbal Tea: _____ | <input type="checkbox"/> Caffeinated tea: _____ | <input type="checkbox"/> Decaf tea: _____ |
| <input type="checkbox"/> Juice: _____ | <input type="checkbox"/> Soda: _____ | <input type="checkbox"/> Soy milk: _____ |
| <input type="checkbox"/> Cow milk: _____ | <input type="checkbox"/> Grain milk: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Green Tea: _____ | <input type="checkbox"/> Nut milk: _____ | <input type="checkbox"/> Other: _____ |

22. Do you drink alcohol? Yes No

If yes, how often daily several times weekly several times monthly seldom

I usually choose : beer red wine white wine sweet or hard liquor

23. Do you currently smoke?

Yes How many cigarettes per day? _____ How long have you smoked? _____

No Have you ever smoked? Yes No If yes, when did you quit? _____

24. Any current or past use of addictive substances and recreational drugs?

Substance: _____ Amount: _____ If quit, when? _____

Substance: _____ Amount: _____ If quit, when? _____

25. Do you experience allergic reactions to any substances (food, environmental, etc.)? Please explain: _____

26. Please describe your work life (1 = least, 5 = most):

Level of stress: (please circle): 1 2 3 4 5 Level of work satisfaction: 1 2 3 4 5

27. Please describe your primary intimate relationship:

Level of stress: (please circle): 1 2 3 4 5 Level of satisfaction: 1 2 3 4 5

28. Are you currently experiencing stress in any other close relationship? _____

Level of stress: (please circle): 1 2 3 4 5 Level of satisfaction: 1 2 3 4 5

29. In what country/countries did your ancestors live in before they came to the United States?

30. What religious / spiritual beliefs were you raised with? _____

31. What are your current religious / spiritual beliefs? _____

32. Do you have any specific spiritual practices now? Please describe _____

33. Sexual Activity

According to Ayurveda, a person’s level of sexual activity impacts health and well-being in the same way as other aspects of daily life – such as diet or sleep. *Are you sexually active?* Yes No

With partner: Daily Several times per week Several times per month Occasionally Not at all

Without partner: Daily Several times per week Several times per month Occasionally Not at all

Is your current sexual activity satisfactory? Yes No

DIETARY PATTERNS

Please indicate your primary food choices and meal times:

Meal	Times(s)	Typical Foods and Beverages
Breakfast		
Snacks		
Lunch		
Snacks		
Dinner		
Late Night		

34. *Do you eat for emotional reasons?* Yes No

Food choices: _____

35. *Do you graze, for example have a jar of nuts at your desk at work and eat them throughout the day?* Yes No

Food choices for grazing: _____

36. *Do you have any routines around eating (say grace, sit in silence before your meal, etc.)?* Yes No

Please explain: _____

37. *Any current or past eating patterns or any other food related issues?* Yes No

Describe: _____

DAILY SCHEDULE

Please describe your activities from the time you wake up until you go to sleep (eating, sleeping, exercise, work, school, other activities). Please include approximate times.

	Time	Activities	
Awaken			<u>Variations</u>
Activities			
Breakfast			
Activities			
Lunch			
Activities			
Dinner			
Activities			
Evening Activities			
Bed-time			

38. How many hours of sleep do you get in 24 hours: _____

39. Do you feel refreshed upon awakening? Always Most days Half the time Rarely Never

40. At end of day: did you have enough energy to do what you wanted to do?

Always Most days Half the time Rarely Never

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

42. Other comments about daily routines: _____

CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, or supplements are you currently taking?
Please include significant remedies that you have recently stopped taking.
Please also include birth control and hormone replacement therapy.

Substance	For each substance, indicate if over-the-counter, M.D. prescription, etc.	Prescribed by whom? (MD, Chiro, Self)	Taken for what purpose?	Taken for how long?	What is your current dosage?	What have been the benefits?
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug					
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug					
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug					
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug					
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug					
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug					

FAMILY MEDICAL HISTORY

Please complete this section only for family members with particular health problems.
If the family member is deceased, please list age at death & cause of death.

	AGE	HEALTH PROBLEMS
Father		
Mother		
Brothers		
Sisters		
Other close blood relatives		

Financial Policy Agreement
for
Jivaka Ayurveda, Inc.

1. There is a \$190 charge for each initial consultation with a Clinical Ayurvedic Specialist. This fee is for the initial consultation lasting approximately two hours. The fee is for information only and does not include any other services or products.
2. There is a \$95 charge for the Report of Findings meeting (1 hour, approx. one week after initial interview) with a Clinical Ayurvedic Specialist.
3. There is a \$95 charge for each follow-up visit (1 hour) with a Clinical Ayurvedic Specialist.
4. There is an additional charge for herbal formulas and other services or products. Fees will be explained to you prior to your purchase. Additional shipping charges may apply. Fees for herbs and products must be paid in advance at the time they are ordered.
5. Fees are due at the time the services are rendered. Jivaka Ayurveda, Inc. does not provide monthly billing.
6. Payment may be made by cash or check only.
7. Jivaka Ayurveda does not bill insurance companies for services, herbs or products.
8. If you miss an appointment without giving 24 hours notice, the full appointment fee will be charged to your account.

I have read and understood the financial policies outlined above.

Client's Signature: _____ Date: _____

INFORMED CONSENT

to receive Complementary Health Care through

Jivaka Ayurveda, Inc.

All clients who participate in Ayurvedic health care should be advised of the following information:

1. Ayurveda is the traditional healing system of India, and is based on the idea that each person's path toward optimal health is unique. Your program is based on understanding your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aromatherapy, massage therapy, and other natural therapeutics. The goal of all programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.
2. Jivaka Ayurveda, Inc. is not a Medical Facility.
3. **Employees of Jivaka Ayurveda, Inc. are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.**
4. Rob Talbert, the principle of Jivaka Ayurveda, Inc., is a Clinical Ayurvedic Specialist. He is not a Medical Doctor. He is a graduate of the California College of Ayurveda, Grass Valley, CA
5. The National Institute of Health Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003. Ayurvedic consultations are considered alternative or complementary to healing arts that are licensed by the State of California.
6. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If you are referred to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
7. No one in association with Jivaka Ayurveda, Inc. may recommend altering your prescriptions without the approval of your medical doctor. Your practitioner may suggest that you speak to your doctor about reducing medication when he/she feels that it is appropriate.
8. While your practitioner may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, your practitioner is evaluating their findings from an Ayurvedic perspective only and not from a Western medical perspective. **This examination does not take the place of a medical evaluation. If, as a result of their examination, any findings suggestive of a possible medical imbalance is found, your practitioner will refer you to a Medical Doctor for further evaluation.**
9. **The following services Not offered by Jivaka Ayurveda, Inc.:**
 - **Diagnosis of pathological conditions**
 - **Treatment for pathological conditions**
 - **Prescription drugs or medicine**
 - **Advice or counseling regarding the diagnosis or treatment of pathological conditions**

I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with Jivaka Ayurveda, Inc.

Client's Signature: _____

Date: _____

Directions

To

Jivaka Ayurveda

481 Osgood Court
Laguna Beach, CA 92651
Phone: 949-497-3134

Directions from the North (Los Angeles)

From the 5 or 405 take CA-133 (Laguna Canyon Road)

All the way to Main Beach.

Turn Left (south) on PCH.

Go 1.4 miles to a signal at DIAMOND ST.

Turn left (away from the ocean) and go up 2 blocks to CATALINA.

Turn Right on Catalina and go one short block to OSGOOD Court.

Turn Left (uphill) and go to the top of the block.

My house is the last house on the right. The street ends into my driveway.

To park just pull up on to the driveway.

Path to front door is to the right. Ring bell to the left of the gate.

Directions from the South (Oceanside)

From Hwy 5 heading north, take the PCH/Beach Cities exit in Dana Point

Go through Dana Point and South Laguna.

Pass the Montage Resort. Pass a signal at Nyes Place.

To a signal at DIAMOND ST (1.4 miles before Downtown Laguna Beach).

Turn right (away from the ocean) and go up 2 blocks to CATALINA.

Turn Right on Catalina and go one short block to OSGOOD Court.

Turn Left (uphill) and go to the top of the block.

My house is the last house on the right. The street ends into my driveway.

To park just pull up on to the driveway.

Path to front door is to the right. Ring bell to the left of the gate.

