



Targeted Consultation Form

This form allows me to prepare your Targeted Consultation in order to offer 2 to 3 recommendations adapted to your daily life. The information collected is strictly confidential and stored securely. No information will be shared without consent, except where required by law. **Please complete this form carefully and return it by email no later than the day before your appointment.**

1. Your main priority

What is the main reason you booked this Targeted Consultation ?

2. Dietary habits

Do you follow a particular diet or nutrition program? Yes No

If yes, which one?

Do you have any food allergies or intolerances? Yes No

If yes, which ones?

Among the following options, check those that correspond to a habit (3 times per week or more):

- I eat quickly
- I eat while doing something else (screen, work, etc.)
- I sometimes skip a meal despite being hungry
- I sometimes eat without hunger
- I sometimes eat beyond satiety
- I usually snack between meals
- I usually eat dinner late (after 8 pm)
- I often eat outside the home (restaurant, cafeteria)
- I regularly use canned, prepared, frozen foods or leftovers

3. Your current daily rhythm (very important)

☞ Please describe a recent, ordinary day that is representative of your daily life (not an exceptional day).

Date : _____

Quality of sleep	Light Broken Restful Excessive / difficult to wake up
Wake-up time	_____
Time of getting up (<i>if different from wake-up</i>)	
Appetite on waking	None Weak Good Intense
Breakfast time	_____
Breakfast menu (foods and drinks)	
Sensations after breakfast (<i>e.g.: light / satisfied / heavy / bloating / drowsiness / discomfort / mental clarity or brain fog</i>)	
Morning activities and snacks	
Appetite before lunch	None Weak Good Intense
Lunch time	_____
Lunch menu (foods and drinks)	
Sensations after lunch (<i>e.g.: light / satisfied / heavy / bloating / drowsiness / discomfort / mental clarity or brain fog</i>)	
Afternoon activities and snacks	
Appetite before dinner	None Weak Good Intense
Dinner time	_____
Dinner menu (foods and drinks)	
Sensations after dinner (<i>e.g.: light / satisfied / heavy / bloating / drowsiness / discomfort / mental clarity or brain fog</i>)	
Evening activities and snacks	
Bedtime	_____
Time of falling asleep (<i>if different</i>)	
Bowel movement time(s) (<i>if applicable</i>)	_____
Emotions / general mood during the day	



Is this day representative of your usual routine?

Yes Partly No

If not, how is it different? _____

4. Additional information

Your general energy level lately:

- Stable and sufficient
- Variable
- Frequent fatigue
- Exhaustion

Do you have any other important information to report

(for example: current health condition, medications affecting digestion, energy, or sleep)?

5. Final declaration

I understand that this Targeted Consultation aims to offer a few personalized recommendations regarding lifestyle and/or nutrition and does not constitute a full Ayurvedic consultation.

I confirm that the information provided is accurate to the best of my knowledge and agree to receive the recommendations offered within this framework.

I understand that the information shared is confidential and used only within the context of this support.

Date : _____

Client signature: _____



Réservé à la praticienne

Observations générales lors de la séance

Vikrti potentielle : _____

Prakrti potentielle : _____

Dhatus potentiellement viciés : _____

Srotamsi potentiellement viciés : _____

