ReViva

Intake Form – Follow-up Consultation

This form allows me to assess changes since our last appointment, identify what has been easy or more difficult to put in place, and adapt the support provided during your follow-up consultation as well as possible. The information collected is strictly confidential and securely stored. **Please fill in this form carefully and return it to me by email, no later than the day before your appointment.**

Online Consultation ?

If this follow-up consultation is taking place remotely, please send me, in addition to this form, two recent selfies, ideally taken in the morning on an empty stomach:

- a close-up of your eyes, while looking sideways
- a close-up of your tongue, extended naturally

These elements allow me to compensate for the limitations of observation via video call, and to prepare our exchange as best as possible.

Before You Start

This consultation corresponds to:

☐ **A follow-up consultation, or picking up where we left off after some time away, to continue an on ongoing health journey** *-> fill-in* ***sections 1 to 7*** *(don not fill-in the journal in annex)*

☐ A consultation **for an entirely new concern, on a subject different from those previously discussed,** particularly if our last consultation was several months ago -> *fill-in* ***sections 1, 5, 6, 7, as well as the journal in annex***.

1. Your Current Priorities

Compared to our last appointment, your health goals :

☐ Are broadly the same

☐ Have changed (adjustment, evolution)

☐ An entirely new concern has emerged

If your goals have evolved or changed, please briefly specify :

What do you expect from this consultation?

☐ An overall review of progress since the last appointment

☐ Adjusting the existing recommendations and/or moving on to the next step of the process

☐ Exploring certain aspects in greater depth

☐ Other : ______________________________

2. Progress on Main Concerns *(follow-up)*

Regarding the concern(s) discussed during our last consultation, would you say the situation is:

☐ Improving
☐ Stable
☐ Variable / fluctuating
☐ Getting worse

Would you like to specify?

3. Other changes observed *(follow-up))*

Have you noticed any changes since our last appointment, even if they are not directly related to your original reason for consulting? Check all that apply:

☐ Appetite
☐ Relationship with food
☐ Digestion or elimination
☐ Energy levels
☐ Sleep
☐ Emotions / mental state
☐ Pain or discomforts
☐ Other
☐ *No notable changes*

If you wish, please highlight one or two noteworthy elements:

4. Applying recommendations *(follow-up)*

Among the recommendations made during our last appointment:

☐ I implemented the majority of the recommendations
☐ I implemented some of the recommendations
☐ I tried but without consistency
☐ I was unable to put them in place

If you wish, you can specify which ones you were able / not able to put in place:

If you implemented some or all of the recommendations, what helped you do so?

☐ The goals and purpose of these recommendations were clear
☐ The instructions on how to implement them were clear
☐ I noticed positive effects quickly
☐ These recommendations matched my preferences or things I enjoy doing (e.g. cooking, walking, routines)
☐ I had enough time and mental space
☐ I could rely on external support (people around me, organisation, living environment)
☐ Other:____

If you tried without consistency or were unable to put any recommendations in practice, what made the recommendations difficult or impossible to apply?

☐ The goals or purpose of these recommendations were not clear
☐ I was not sure exactly how to put them into practice
☐ The effects I experienced were uncomfortable or difficult to manage
☐ The activity itself did not appeal to me
☐ Lack of time or day-to-day overload
☐ Lack of support or constraints related to those around me
☐ Practical or financial constraints
☐ Other: ____

5. Recent Life Context

Since our last appointment, have there been any significant changes or events to report?

☐ Professional /work-related changes
☐ Change of home or living situation
☐ Separation / relational changes
☐ Period of intense stress
☐ Other notable event: ____
☐ *No notable change/event*

If yes, you may specify:

6. Medical Update

Since our last appointment, are there any new elements to report?

☐ New symptoms
☐ New medical diagnosis
☐ New medical treatment
☐ Modification of an existing treatment
☐ Accident or surgical procedure
☐ Starting or stopping dietary supplements
☐ *No change*

If yes, you may specify:

7. Final Declaration

I understand that this follow-up consultation is part of an Ayurvedic support approach and does not replace medical follow-up.

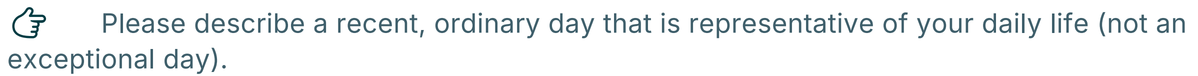
I confirm that the information provided is accurate to the best of my knowledge, and I agree to receive the recommendations made within this framework.

I understand that the information shared is confidential and used solely within the context of this service.

Date : ____________________ Signature : __________________________________

7. Appendix – Journal of an Ordinary Day

To be completed only in the case of a consultation for an entirely new concern.



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