ReViva

Intake Form – Foundational Assessment

This questionnaire allows me to better understand your current situation, your lifestyle, and the factors that may influence your state of health, in order to prepare our first consultation as effectively as possible and allow more time for discussion. The information collected is strictly confidential and stored securely. **Please complete this form carefully and return it by email no later than the day before your appointment.**

Online consultation ?

If this consultation takes place remotely, please send me the following recent photos in addition to this form:

- 2 full-body photos of yourself (front, profile)
- 1 close-up of your face
- 1 close-up of your eyes, looking slightly to the right or left
- Close-up of both hands, palms facing downward
- Close-up of your tongue, naturally extended (ideally in the morning on an empty stomach)

These photos are traditional observational elements in Ayurveda and allow me to compensate for the limitations of a videocall.

1. Informations personnelles

Name, Surname:		Height (cm):	
Date of birth:		Weight (kg):	
Birth place:		Main occupation:	
Place(s) where you grew up (if different from place of birth):		Age(s) of your children (if applicable):	
Preferred pronouns (optional):		Living situation (alone, shared housing, etc.):	

2. Reason for the consultation

I am consulting today mainly in order to *(multiple answers possible)* :

☐ Establish the foundations for support over several sessions

☐ Prepare for follow-up with specific body therapies

☐ Address a specific health concern

☐ Understand my Ayurvedic constitution and the main principles of Ayurveda in order to become more autonomous in managing my health

☐ I do not have a specific concern but wish to improve my overall balance.

☐ Other objective: _____

What are your current health concerns (physical, emotional, or other)?

What improvements would you like to see?

Is there a particular point, question, or topic you definitely want to address during this first consultation?

3. Medical history & vulnerabilities

Are you currently being followed by a healthcare professional? ☐ Yes ☐ No

Do you take medications or supplements? ☐ Yes ☐ No

If yes, please specify (name and reason):

Do you have allergies? ☐ Yes ☐ No

If yes, please specify:_____

Please indicate if any of the following applies to you currently or recently:

☐ Pregnancy or planning pregnancy
☐ Recent surgery or ongoing injury

If yes to either of these, please briefly specify (nature, date, context):

Please indicate whether you are currently, or have been, affected by:

☐ Chronic digestive disorders (intolerances, IBS, colitis, Crohn's , GERD, etc.)
☐ Hormonal or metabolic imbalances (thyroid disorders, diabetes, cholesterol, anemia)
☐ Cardiovascular problems (blood pressure, heart issues, stroke, edema)
☐ Inflammatory or autoimmune disorders
☐ Musculoskeletal disorders (arthritis, joint pain)
☐ Chronic respiratory problems (asthma, recurrent infections)
☐ Neurological or sensory disorders (migraines, glaucoma, multiple sclerosis)
☐ Persistent psychological or emotional disorders (anxiety, depression, addictions)
☐ Cancer (current or past)
☐ Other significant condition: _____

Have there been significant events in your life that have had an impact on your health or balance? *(accident, serious illness, intense stress, bereavement, etc.)*

○ Yes ○ No

If yes, please briefly specify:

Over the past 6 months, how often have you been ill (colds, infections, feverish episodes)?

○ Rarely or never
○ 1 to 2 times
○ 3 to 4 times
○ More than 4 times
○ Difficult to say

4. Lifestyle, rhythm & emotions

Physical activity

Do you have a regular physical activity? ○ Yes ○ No

If yes, which activity/activities ?

average, how many hours per week?

Time for yourself and your relationships

How often do you take time for:

- **Yourself**
  ○ Almost every day ○ At least once a week ○ Less often
- **Your hobbies / leisure activities**
  ○ Almost every day ○ At least once a week ○ Less often
- **Social relationships (friends, outings, exchanges)**
  ○ Almost every day ○ At least once a week ○ Less often

Stress, fatigue & sleep

How would you currently rate:

- Your stress level (1 = very low, 10 = very high): ___ /10
- Your level of fatigue (1 = very low, 10 = very high): ___ /10

How would you describe your sleep at the moment?

☐ Restorative
☐ Light
☐ Fragmented / interrupted
☐ Excessive / difficult to wake up in the morning

Do you wake up at night to pee? ○ Yes ○ No

If yes, how many times per night? _____

Habits and environment

Do you smoke?

☐ Yes ☐ No ☐ In the past yes, but not at the moment

Do you use recreational substances?

☐ Yes ☐ No ☐ In the past yes, but not at the moment

Do you have pets at home? ☐ Yes ☐ No

Have you moved house twice or more in the past two years?

☐ Yes ☐ No

Current emotional state

What emotions are most present for you at the moment?

(positive and/or negative, according to what you wish to share)

5. Dietary habits

Have you ever followed a specific diet or nutritional program?

☐ Yes ☐ No

If yes, for what reason(s)? _____

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 skip a meal despite being hungry
☐ I eat even if I'm not hungry
☐ I keep eating even if I'm already full

☐ I eat snacks inbetween meals
☐ I eat dinner late (after 8 pm)

☐ I often eat outside the home (restaurant, cafeteria)
☐ I regularly use canned, prepared, frozen foods or leftovers
☐ My meals depend heavily on professional or family constraints

What beverages & stimulants do you usually drink?

☐ Coffee/tea
☐ Alcohol
☐ Energy drinks
☐ Sodas or fruit juices
☐ Cold or iced drinks
☐ None of these

6. 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 (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	

Is this day representative of your usual routine?

○ Yes ○ Partly ○ No

If not or partly, how is it different?? _____

7. Sexual health

Are you currently using contraception or hormonal treatments? ○ Yes ○ No

If yes, which one(s) and since when? _____

How would you currently rate your libido compared to what is normal for you?

○ Lower than usual ○ No change ○ Higher than usual ○ Not sure

If relevant, check the topics that currently concern you or are part of your concerns:

☐ Irregular, absent, or painful menstrual cycles
☐ Significant premenstrual or peri-menstrual symptoms
☐ Perimenopause / menopause / andropause
☐ Difficulty conceiving or interrupted pregnancies
☐ Libido or sexual function disorders
☐ Other concern related to sexual or hormonal health

If yes, please briefly specify:

8. Final declaration

*I understand that this consultation is part of an Ayurvedic support approach and **does not under any circumstances replace medical advice, medical supervision, prescribed treatment, or medical care.***

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 solely within the context of this support.

Date : _____

Client signature : _____