CHECKLIST

Date	
Name:	D.O.B
Phone Number:	Email:

Address	

Sleep	Light_____ Moderate_____ Heavy _____
Difficulty falling asleep ? Yes / No	Difficulty staying asleep ? Yes / No
What time do you go to sleep ? _____	What time do you wake up ?_____
Difficulty on arising? Yes / No	Frequent urination at night? Yes / No

Digestion and appetite	
Appetite: Steady / Erratic / Fussy	Digestion: Bloating / Gas / Cramping
Digestive issues/ Food sensitivities	How much water do you drink each day? _____

Elimination	
Regular ? _____	
Urination : how many times a day? _____	

Monthly Cycle	
Length of cycle	Regular/Irregular cycle
Bloating: Before/During	Flow: Scanty/Regular/Heavy
Weepy/irritable/irrational/PMS	Cramping at onset of flow or during flow
Achy back? Yes / No	Fatigue? Yes / No
Peri Menopausal_____	Menopausal_____

Social Type	

Date	
Do you prefer being alone or being in company?	Are you talkative or quiet when in company?
What is your favorite activity?	

How do you react under stress?	
Get angry and frustrated with people? Yes / No	Get anxious at what others might think? Yes / No
Cannot stop the planning mind? Yes / No	Repetitive thoughts? Yes / No
Mental restlessness? Yes / No	Distracted and difficulty focusing? Yes / No
Micromanagement? Yes / No	Highly motivated? Yes / No

Others	
Neck and shoulder pain or headaches? Yes / No	Back aches? Where?
Other physical problems	

Others	
What would you most like to change about yourself ?	