amy landry
LIVING IN ALIGNMENT

CLIENT CONSULTATION FORM

Name:

Address:

Email:

Occupation:

Place of birth:

Emergency contact name:

Emergency contact tel:

Date:

DOB:

Phone:

Gender:

Current symptoms & their duration

(Consider digestive health, sleep quality, immunity, respiratory health, sources of pain, adrenal issues, etc):

Current medications (Include any herbs or supplements)

Previous medications

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History of any serious illness (including any and all types of injury and mental illnesses):

Are you currently receiving any treatment for any injuries or illness? If so, what and with whom?

Do you have asthma? Y | N

Do you have a pancreas? Y | N

Family history, maternal:

Family history, paternal:

Diet: Vegan | Vegetarian | Pescatarian | Paleo | Gluten Free | None

Appetite (eg. weak, strong, changeable):

Meal times: breakfast lunch dinner

Meal choices:

Breakfast

Lunch

Dinner

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Current Daily Routine (From the moment you get up - urinate, make coffee, brush teeth, etc... in detail!)

FEMALES

Are you pregnant? Y | N

Number of months:

Have you previously had children? Y | N

If yes, how many?

Any pregnancy complications?

Last menstrual period:

Days between cycles:

Days of menstruation:

Menstruation colour:

Any clotting? Y | N

Regular cycles? Y | N

PMS / Tender breasts? Y | N

Pain during period? Y | N

Birth control pill? Y | N

Amount of bleeding: Heavy | Moderate | Light | NA

History of cervical cancer?

Abnormal pap smears?

Please add any other relevant and related information to your pregnancy/menstruation/menopause symptoms and history:

RESPIRATION

Describe the normal quality of your breathing (include information about sinusitis and asthma):

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HYDRATION

Glasses of water per day (not including coffee, tea, sugary drinks, juice)?

QUALITY OF NAILS

Strong | Weak | Brittle | Dry | Cracked

Short | Bitten | Pale white | Pale pink

Vertical ridges | Dry cuticles

QUALITY OF HAIR

Thin | Thick | Wavy | Straight | Curly

Falling out | Thinning | Receding | Brittle

Brunette | Black | Grey | Strawberry blonde | Red | Blonde

NADI / PULSE

If conducting consultation via skype, please take your pulse just after waking (resting pulse) and note how many beats per minute:

JIWHA / TONGUE

If conducting consultation via skype, please take a photograph of your tongue and upload it/send through.

BOWEL

Do you have a bowel movement every day? Y | N

Do you experience gas or bloating? Y | N

Do you experience regular diarrhoea? Y | N

Have you been formally diagnosed with IBS? Y | N

How many times a day do you pass stool?

Is there currently an unusual or bad odour?

How many pieces of stool pass each time?

Quality of stool (dry, loose, mucousy, etc):

Any diagnosed condition with your colon?

History of fissures or haemorrhoids?

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URINATION

Do you awake to urinate during the night? Y | N

Do you have frothy urine? Y | N

What colour is your urine on average? (exclude the first urination of the day)

Any pain whilst urinating?

History of bladder infection or UTIs?

History of kidney stones or disease?

VOICE / THROAT

Any history of glandular fever?

Do your neck lymph glands swell often?

Are you susceptible to getting a sore throat at the first sign of being run down?

Quality of your voice (eg. quiet, hoarse, dry, loud, cracking, etc)?

SKIN

Do you have any history of skin cancer? Y | N

Do you use sunscreen? Y | N

Quality of your skin (eg. dry, prone to acne, eczema, oily, etc)?

What products do you use on your skin, including deodorant?

Quality of circulation (do you get cold hands and feet)?

Quantity of sweat (heavy, light, etc)?

Do you have excessive ear wax?

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AKRITI / FACIAL EXPRESSIONS / LINES

Do you have any specifically notable markings on your face (eg. deep horizontal grooves across forehead, or deep vertical line between eyes)?

NETRA / EYES

Do you wear prescription glasses? Y | N

Size of eyes (eg. large, round, small, almond shaped)

Eye colour?

Quality of eyelashes (thin, thick, short, long)?

Are you prone to red, itchy, dry eyes?

Any notable traits or features of your eyes?

MIND

Please describe your current mental / emotional state:

Have you any history of diagnosed mental illness? If so, please describe:

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Anything else you would like to add?

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