FOLLOW UP FORM

Please indicate any physical and emotional patterns that *you find challenging* by assigning a ***Frequency*** (a number of times per week, month or year) and ***Intensity*** (a number from 1 to 10):

INTENSITY OF DISCOMFORT:

1 TO 3 = MILD; 4 TO 6 = MODERATE; 7 TO 10 = SEVERE

DIGESTION

	Frequency Number of times per week, month or year	Intensity 1-10
Excessive gas/ burps		
Bloated after eating		
Acidity/ reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy/ heaviness after eating		
Appetite/hunger		

EMOTIONS

	Frequency Number of times per week, month or year	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

ELIMINATION

	Frequency Number of times per week, month or year	Intensity 1-10
Constipation (less than1 BM/day)		
Alternating constipation & loose stool		
Undigested food in stool		
Diarrhea (loose stool)		
Rectal pain/ Hemorrhoids		
Blood in stool		
Mucus in Stool		
Abdominal pain		

Is there a foul smell: _____

Well-formed/fragmented/float/sink _____

Color: dark brown/yellowish/pale whitish _____

URINE:

Which words describe your urine? Dark/ pale/ turbid/ painful/ scanty/ difficult/ frequent/ dribbling/ incontinence/ blood in urine/ burning sensation

Do you wake up at night to use the toilet? How many times?

_____

Is there a foul smell? _____

Please describe your energy level: _____

_____

Sleep Pattern/ quality: _____

PRACTITIONER USE ONLY:

Vikruti	V:	P:	K: