SIRILAKSHMI
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Kundalini Medicine Assessment Form

Name_____

DOB _____ Age _____ Occupation _____

Address_____

_____Postcode_____

Email _____

Mobile No_____

What would you like the treatment for?

Are you on any prescribed on self-prescribed medication Yes/No
Please list them and why you take them:

What is your medical history – Have you had any serious conditions?
Have you had surgery or operations?

How is your energy?
Are you short of breath?
Do you suffer from palpitations?
Is there any pain in the body, when do get the pain ?(AM/PM)
Do you suffer from migraines and headaches?
Do sleep well?
Do you sweat easily or not easily?

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How is your appetite?

How is your digestion and your elimination (constipation, Diarrhoea, looseness)
How is urination – do you have nocturia, frequency or urgency of urination?

How is your diet?

Do you suffer from Heartburn?
Do you feel distention or tired after eating?

How is your menstrual cycle?
How many days?
How long does it last?
Heavy, medium or light flow
Any pain / any pms

Are you stressed?

Are you smoker – How many a day?
How much alcohol do you drink?
Do you take any recreational drugs?
How is your hair/nails/skin?
What is the main challenge in your life?
Anything else you wish to tell me? (hobbies, what makes you happy, about your creative side)

Signature _____ Date _____

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