TANTRA ESSENCE PRESENTS

MenoDawn

New Era of the Menopause Cycle

◆ ◆ ◆

Your Confidential *Client Questionnaire*

HEALTH · HORMONES · HABITS · HEART

"Menopause is the dawn of the woman you were always becoming."

Before you begin

This form can be filled in directly on your computer, tablet or phone — click any field and type, and click the small squares to tick them. Nothing needs to be printed.

When you have finished: save the file with your own name — for example
MenoDawn-Questionnaire-Maria.pdf — and send it back to me.

Please answer as fully and as honestly as you can. If a question does not apply to you, leave it empty. If something feels too tender to write, you may write "in person" and we will speak of it together. There are no wrong answers here — only your truth, which is exactly what I need.

Everything you write is held in complete confidence.

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Transpersonal Healer · Women's Empowerment Teacher · Tantric Teacher
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What these pages will ask you

01	Your Details	*Let us begin with the simple things.*
02	Your Birth Data	*So that I may look at the map of your becoming.*
03	Where & How You Live	*Your body is always in conversation with your surroundings.*
04	Your Menopause Journey	*The heart of it. Take your time here.*
05	Menstrual, Gynaecological & Reproductive History	*The whole arc of your womb's life.*
06	Contraception — Your Whole History	*This tells me a great deal about your hormonal terrain.*
07	Hormone Therapy, Herbs & Supplements	*Everything you take, in whatever form.*
08	Medical Tests & Blood Work	*Bring me your numbers, and I will read them alongside your story.*
09	Thyroid & Adrenals	*The two quiet engines beneath everything.*
10	Your Medical Story	*Everything that has passed through this body.*
11	Safety & Care In Our Work Together	*So that what I offer you is right for your body, and never harmful.*
12	Eating, Digestion & Nourishment	*Food is the medicine we take three times a day.*
13	Movement, Body & Touch	*How you inhabit the form you were given.*
14	Sleep & Rest	*The most honest measure of a nervous system.*
15	Stress, Nervous System & Emotional Landscape	*What your body has been asked to carry.*
16	Meditation, Practice & Inner Life	*The thread that runs through everything I teach.*
17	Intimacy, Sexuality & Relationship	*Held in complete confidence. Answer only what you wish to.*
18	What You Put On Your Skin & Use At Home	*The invisible daily dose. Brands and names are very welcome.*
19	Your Days, Your Habits, Your Joy	*Who you are when nobody needs anything from you.*
20	Your Intention	*Why now, and what is calling you.*
21	Consent & Confidentiality	*Your words are held in trust.*

01 Your Details

Let us begin with the simple things.

First name

Family name

The name you like to be called

Age today

Date completed

Email

WhatsApp / Telegram / Mobile (with country code)

Country of residence

City / town

Time zone

Nationality

Mother tongue

Other languages you speak

Your work / profession

Working hours per week

Height (optional)

Weight (optional)

Have you noticed weight changes? Where and when

In case of emergency

Emergency contact — name

Relationship to you

Phone (with country code)

Your doctor / GP name and contact (optional)

Health / travel insurance

How did you find your way to MenoDawn?

- ☐ Instagram
- ☐ Facebook
- ☐ TikTok
- ☐ Website
- ☐ Google search
- ☐ A friend / word of mouth
- ☐ Tantra Essence
- ☐ A previous workshop
- ☐ Ma Ananda Sarita
- ☐ Oracle Cards or Book
- ☐ Newsletter
- ☐ Other

What are you enquiring about?

- ☐ The MenoDawn retreat
- ☐ One-to-one sessions
- ☐ ColorLight therapy
- ☐ Tachyon session
- ☐ Ito-Thermie
- ☐ Online session
- ☐ A training
- ☐ Not sure yet

02 Your Birth Data

So that I may look at the map of your becoming.

> *Your birth time matters — even fifteen minutes changes the picture. Please look at your birth certificate if you can.*

Date of birth (day / month / year)

Time of birth (as exactly as you know)

Was it am or pm?

Place of birth — city / town

Region / state

Country

Where does your birth time come from?

- ☐ Birth certificate
- ☐ Hospital record
- ☐ My mother's memory
- ☐ A family story
- ☐ An estimate
- ☐ I don't know it

If you know them: Sun sign

Moon sign

Rising / Ascendant

Chinese or Vedic sign

How familiar are you with astrology, numerology or human design?

- ☐ Not at all
- ☐ A little
- ☐ Quite familiar
- ☐ I study or practise it

Do you give permission for your birth data to be used to prepare a chart for your reading? ☐ Yes ☐ No

Is there anything you know about your birth itself — the season, the circumstances, whether it was easy or difficult, early or late, and what your family have told you about it?

Were there significant events during your mother's pregnancy with you, or in your first years of life, that you know about?

03 Where & How You Live

Your body is always in conversation with your surroundings.

What kind of place do you live in?

- ☐ Big city
- ☐ Small town
- ☐ Village
- ☐ Countryside
- ☐ By the sea
- ☐ In the mountains
- ☐ Forest / green area
- ☐ Desert / dry climate
- ☐ Tropical climate
- ☐ Cold climate
- ☐ Near a main road
- ☐ Industrial area

How many years have you lived there?

Altitude, if high

How much daylight in winter where you live?

Who do you share your home with?

- ☐ I live alone
- ☐ Partner / spouse
- ☐ Children at home
- ☐ Adult children
- ☐ Grandchildren
- ☐ My parents
- ☐ Partner's parents
- ☐ Siblings
- ☐ Housemates / flatmates
- ☐ Community / ashram
- ☐ Pets
- ☐ It changes often

How does living with these people feel for you day to day? Is your home a place of rest, or of demand?

How safe, held and at home do you feel in your living space?

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely

Is your home affected by any of these?

- ☐ Damp or mould
- ☐ Poor ventilation
- ☐ Noise
- ☐ Street light at night
- ☐ Dust
- ☐ Smoking indoors
- ☐ New paint / furniture
- ☐ New carpets
- ☐ Renovation work
- ☐ Air pollution outside
- ☐ Pesticide spraying nearby
- ☐ Radon or known contamination
- ☐ None of these

Your water and air at home

- ☐ Tap water, unfiltered
- ☐ Filtered water
- ☐ Bottled water (plastic)
- ☐ Bottled water (glass)
- ☐ Spring or well water
- ☐ Water softener
- ☐ Air purifier
- ☐ Humidifier
- ☐ Air conditioning
- ☐ Wood fire / stove
- ☐ None of these

Does your work expose you to any of these?

- ☐ Chemicals or solvents
- ☐ Hair colour / salon products
- ☐ Nail products
- ☐ Cleaning products
- ☐ Paints or glues
- ☐ Pesticides / farming
- ☐ Laboratory work
- ☐ Medical radiation
- ☐ Printing / inks
- ☐ Heavy metals
- ☐ Night shifts
- ☐ Long-haul flying
- ☐ Screens all day
- ☐ Physically heavy work
- ☐ No exposure

Hours a week you spend outdoors in daylight

Hours a week in nature (forest, sea, mountain)

Do you see the sunrise?

Do you travel often, or cross time zones? Please describe your pattern.

04 Your Menopause Journey

The heart of it. Take your time here.

Where are you in the passage right now?

- ☐ My cycle is still regular
- ☐ My cycle has become irregular (perimenopause)
- ☐ No period for 3–11 months
- ☐ No period for 12 months or more (menopause)
- ☐ Several years post-menopause
- ☐ Surgical menopause (ovaries removed)
- ☐ Menopause after cancer treatment
- ☐ Menopause induced by medication
- ☐ I am not sure

Date of your last menstruation	Age when the first changes began	Age you became fully menopausal, if applicable

If still cycling: usual length of cycle (days)	Length of bleeding (days)	Heavy, light, or changing?

> *Below, please tick the column that matches how you experience each thing at the moment. Leave blank anything you have never experienced.*

Body and temperature

	NEVER	MILD	MODERATE	STRONG
Hot flushes (how many per day?)	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Cold flushes or chills	☐	☐	☐	☐
Palpitations, racing heart	☐	☐	☐	☐
Dizziness or light-headedness	☐	☐	☐	☐
Headaches or migraines	☐	☐	☐	☐
Joint pain or stiffness	☐	☐	☐	☐
Muscle aches, loss of strength	☐	☐	☐	☐
Electric-shock sensations	☐	☐	☐	☐
Tingling in hands or feet	☐	☐	☐	☐
Restless legs	☐	☐	☐	☐
Tinnitus (ringing in the ears)	☐	☐	☐	☐
Dry eyes	☐	☐	☐	☐
Dry mouth or burning mouth	☐	☐	☐	☐
Gum or dental changes	☐	☐	☐	☐
Changed body odour	☐	☐	☐	☐
New or worsened allergies	☐	☐	☐	☐

Mind and mood

	NEVER	MILD	MODERATE	STRONG
Anxiety	☐	☐	☐	☐
Panic or sudden dread	☐	☐	☐	☐
Low mood or depression	☐	☐	☐	☐
Rage or sudden anger	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐

	NEVER	MILD	MODERATE	STRONG
Tearfulness				
Brain fog				
Losing words mid-sentence				
Forgetfulness				
Trouble concentrating				
Loss of confidence				
Feeling not like myself				
Overwhelm at small things				
Loss of motivation or joy				

Sleep and energy

	NEVER	MILD	MODERATE	STRONG
Difficulty falling asleep				
Waking in the night				
Waking at 3–4am				
Waking too early				
Unrefreshing sleep				
Exhaustion during the day				
Afternoon energy crash				
Wired but tired at night				

Skin, hair and shape

	NEVER	MILD	MODERATE	STRONG
Dry, thinning or itchy skin				
Crawling sensation on skin				
Hair thinning or loss				
New facial hair				
Brittle nails				
Weight gain around the middle				
Bloating				
Breast tenderness or change				
Loss of skin firmness				

Intimate and urinary

	NEVER	MILD	MODERATE	STRONG
Vaginal dryness				
Itching or burning				
Pain during intercourse				
Loss of libido				
Difficulty reaching orgasm				
Urinary urgency				
Leaking with cough or laughter				
Recurrent urine infections				
Recurrent thrush				
Pelvic heaviness or prolapse				

Which three symptoms trouble you most, and how do they affect your daily life?

What have you already tried for these, and what helped or did not help?

Is there anything that makes your symptoms clearly better or clearly worse — foods, wine, coffee, heat, stress, particular people, particular days?

What did your mother's, grandmother's or sisters' menopause look like? At what age? What was said about it in your family?

When you hear the word 'menopause', what feelings arise in you? Please be honest — there is no wrong answer.

05 Menstrual, Gynaecological & Reproductive History

The whole arc of your womb's life.

Age of your first period

How was it for you? (welcomed, frightening, hidden…)

Across your fertile years, your cycle was mostly:

- ☐ Regular
- ☐ Irregular
- ☐ Very heavy
- ☐ Very light
- ☐ Painful
- ☐ Pain-free
- ☐ Long (35+ days)
- ☐ Short (under 25 days)
- ☐ Absent for periods of time

Have you experienced any of these?

- ☐ PMS
- ☐ PMDD
- ☐ Endometriosis
- ☐ Adenomyosis
- ☐ PCOS
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Heavy bleeding (menorrhagia)
- ☐ Absent periods (amenorrhoea)
- ☐ Painful periods
- ☐ Ovulation pain
- ☐ Recurrent thrush
- ☐ Bacterial vaginosis
- ☐ HPV
- ☐ Abnormal smear
- ☐ Pelvic inflammatory disease
- ☐ Prolapse
- ☐ Interstitial cystitis
- ☐ None of these

Number of pregnancies

Number of births

Vaginal / caesarean

Ages you gave birth

Miscarriages (how many, when)

Terminations (how many, when)

Stillbirth or infant loss

Did you breastfeed? For how long in total?

Any difficulty conceiving?

Fertility treatment

- ☐ None
- ☐ Clomid or similar
- ☐ IVF
- ☐ ICSI
- ☐ IUI
- ☐ Hormone stimulation
- ☐ Egg freezing
- ☐ Donor eggs
- ☐ Surrogacy

If you went through fertility treatment, pregnancy loss or a difficult birth — how does that live in you now?

Gynaecological surgery or procedures

- ☐ None
- ☐ Hysterectomy — womb only
- ☐ Hysterectomy — with cervix
- ☐ One ovary removed
- ☐ Both ovaries removed
- ☐ Fallopian tubes removed
- ☐ Endometrial ablation
- ☐ Fibroid removal
- ☐ Cyst removal
- ☐ Laparoscopy
- ☐ D&C
- ☐ LLETZ / cone biopsy
- ☐ Prolapse repair
- ☐ Mesh
- ☐ Caesarean
- ☐ Episiotomy or tearing
- ☐ Labiaplasty
- ☐ Breast surgery
- ☐ Breast implants

If you had surgery — what, and in which year?

Your screening — when were these last done, and what was the result?

SCREENING	DATE	RESULT / WHAT YOU WERE TOLD
Cervical smear / HPV test		
Mammogram		
Breast ultrasound or MRI		

SCREENING	DATE	RESULT / WHAT YOU WERE TOLD
Pelvic or transvaginal ultrasound		
Bone density (DEXA)		
Colonoscopy		
Skin check		
Dental / gum check		

Your pelvic floor

- ☐ Strong, no concerns
- ☐ Some weakness
- ☐ Leaking with cough, laugh or run
- ☐ Urgency
- ☐ Heaviness or bulging
- ☐ Painful
- ☐ I do pelvic floor exercises
- ☐ I have seen a pelvic physiotherapist
- ☐ I don't know how it is

06 Contraception — Your Whole History

This tells me a great deal about your hormonal terrain.

> *Please include everything you have ever used, even for a short time. Brand names are very helpful if you remember them.*

METHOD	BRAND / NAME	AGE STARTED	HOW LONG USED	WHY YOU STOPPED	EFFECTS YOU NOTICED
Combined pill					
Mini pill (progestogen only)					
Hormonal coil (Mirena, Kyleena…)					
Copper coil					
Implant (Nexplanon…)					
Injection (Depo-Provera…)					
Patch					
Vaginal ring					
Emergency contraception					
Condoms / diaphragm					
Fertility awareness / natural					
Sterilisation (tubes tied)					
Partner's vasectomy					
Other					

In total, roughly how many years of your life were you on hormonal contraception?

What are you using now, if anything?

While on hormonal contraception, did you notice any of these?

- ☐ Low mood
- ☐ Anxiety
- ☐ Loss of libido
- ☐ Weight gain
- ☐ Headaches
- ☐ Nausea
- ☐ Breast tenderness
- ☐ Spotting
- ☐ No periods
- ☐ Blood pressure rise
- ☐ Blood clot
- ☐ Skin improved
- ☐ Skin worsened
- ☐ Hair loss
- ☐ Mood swings
- ☐ Felt flat or numb
- ☐ No effects at all

When you came off hormonal contraception, what happened? How long until your own cycle returned?

Were you ever put on the pill for a reason other than contraception — acne, heavy bleeding, pain, cysts, 'to regulate'? Please describe.

07 Hormone Therapy, Herbs & Supplements

Everything you take, in whatever form.

Are you using, or have you used, menopause hormone therapy (HRT/MHT)?

- ☐ Never
- ☐ Currently using
- ☐ Used in the past
- ☐ Considering it
- ☐ Was advised against it
- ☐ Prefer not to use it

If yes — please give what you can:

TYPE	BRAND / FORM	DOSE	STARTED WHEN	HOW IT SUITS YOU
Oestrogen — patch				
Oestrogen — gel or spray				
Oestrogen — tablet				
Progesterone — micronised (Utrogestan…)				
Progestogen — synthetic				
Hormonal coil for the progesterone part				
Testosterone				
Vaginal oestrogen (cream, pessary, ring)				
DHEA				
Compounded 'bioidentical'				
Implanted pellets				

Herbs and plant medicines you take or have taken

- ☐ Black cohosh
- ☐ Sage
- ☐ Red clover
- ☐ Dong quai
- ☐ Maca
- ☐ Ashwagandha
- ☐ Rhodiola
- ☐ Shatavari
- ☐ Vitex / agnus castus
- ☐ Evening primrose
- ☐ Wild yam
- ☐ Soy isoflavones
- ☐ Flaxseed
- ☐ Milk thistle
- ☐ St John's wort
- ☐ Turmeric
- ☐ Ginseng
- ☐ Liquorice root
- ☐ Chinese herbs
- ☐ Ayurvedic formulas
- ☐ None

Supplements you take — please include dose and brand if you can

SUPPLEMENT	DOSE	HOW LONG	WHY YOU TAKE IT

Which of these do you take regularly?

- ☐ Vitamin D
- ☐ Vitamin K2
- ☐ Magnesium
- ☐ B complex
- ☐ B12
- ☐ Folate
- ☐ Iron
- ☐ Calcium
- ☐ Omega 3
- ☐ Zinc
- ☐ Selenium
- ☐ Iodine
- ☐ Collagen
- ☐ Probiotics
- ☐ Creatine
- ☐ Protein powder
- ☐ Melatonin
- ☐ Adaptogens
- ☐ Multivitamin
- ☐ None

08 Medical Tests & Blood Work

Bring me your numbers, and I will read them alongside your story.

> *Please fill in whatever you have, with the date and the units. If you can, attach or email a copy of the actual laboratory report — it tells me more than the numbers alone. If you have never been tested, simply leave it blank; that is information too.*

Hormones

TEST	RESULT + UNITS	DATE	LAB REFERENCE RANGE
FSH			
LH			
Oestradiol (E2)			
Progesterone			
Testosterone — total			
Testosterone — free			
SHBG			
DHEA-S			
Prolactin			
AMH			
Cortisol — morning blood			
Cortisol — saliva (4 point)			
Insulin — fasting			
DUTCH or urine hormone test			

General blood picture

TEST	RESULT + UNITS	DATE	LAB REFERENCE RANGE
Full blood count / haemoglobin			
Ferritin			
Iron / transferrin saturation			
Vitamin B12			
Folate			
Vitamin D (25-OH)			
Calcium			
Magnesium			
Zinc			
Fasting glucose			
HbA1c			
Total cholesterol			
LDL			
HDL			
Triglycerides			
CRP or ESR (inflammation)			
Homocysteine			
Liver — ALT / AST / GGT			
Kidney — creatinine / eGFR			
Uric acid			

Other investigations you have had

- ☐ Bone density (DEXA)
- ☐ Coeliac test
- ☐ Food intolerance test
- ☐ Gut microbiome test
- ☐ SIBO breath test
- ☐ Stool analysis
- ☐ Heavy metals
- ☐ Genetic test (MTHFR, COMT…)
- ☐ Allergy testing
- ☐ Sleep study
- ☐ ECG / heart scan
- ☐ Blood pressure monitoring
- ☐ Thermography
- ☐ Full body scan
- ☐ None

Blood pressure (recent reading)

Resting heart rate

Bone density T-score, if known

What have your doctors said to you about your hormones or your menopause? Do you feel heard by them?

Anything else in your results that concerned you or was left unexplained?

09 Thyroid & Adrenals

The two quiet engines beneath everything.

Has your thyroid ever been investigated or diagnosed?

- ☐ Never tested
- ☐ Tested, all normal
- ☐ Underactive (hypothyroid)
- ☐ Overactive (hyperthyroid)
- ☐ Hashimoto's
- ☐ Graves'
- ☐ Nodules
- ☐ Goitre
- ☐ Thyroid cancer
- ☐ Part or all removed
- ☐ Radioactive iodine
- ☐ Currently being monitored

Your thyroid results — please give what you have

TEST	RESULT + UNITS	DATE	LAB REFERENCE RANGE
TSH			
Free T4			
Free T3			
Reverse T3			
TPO antibodies			
Thyroglobulin antibodies			
Thyroid ultrasound			
Iodine			

Thyroid medication and dose (levothyroxine, NDT, carbimazole…)

How long have you taken it?

Do you experience any of these?

	NEVER	MILD	MODERATE	STRONG
Feeling cold when others are warm	☐	☐	☐	☐
Feeling hot when others are cold	☐	☐	☐	☐
Cold hands and feet	☐	☐	☐	☐
Low body temperature	☐	☐	☐	☐
Hair loss, or loss of outer eyebrow	☐	☐	☐	☐
Dry, coarse skin	☐	☐	☐	☐
Puffy face or eyes	☐	☐	☐	☐
Swelling in the neck	☐	☐	☐	☐
Hoarse voice	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Slow digestion	☐	☐	☐	☐
Heart racing or fluttering	☐	☐	☐	☐
Hand tremor	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐
Weight change without cause	☐	☐	☐	☐
Deep fatigue that sleep does not touch	☐	☐	☐	☐

Adrenals, stamina and the stress response

How is your energy across a day?

	NEVER	MILD	MODERATE	STRONG
Hard to wake, heavy in the morning	☐	☐	☐	☐
Need coffee before I function	☐	☐	☐	☐

	NEVER	MILD	MODERATE	STRONG
Crash in the afternoon				
Second wind late at night				
Dizzy when standing up quickly				
Craving salt				
Craving sugar				
Startle easily at noise				
Feel shaky if a meal is late				
Cannot tolerate stress the way I used to				
Cannot tolerate exercise the way I used to				
Feel wired and exhausted at once				

Have you ever been through burnout, adrenal exhaustion, chronic fatigue, long covid or a collapse of your energy? When, and what brought you back?

10 Your Medical Story

Everything that has passed through this body.

Have you been diagnosed with any of these?

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Stroke or TIA
- ☐ Blood clot / DVT / embolism
- ☐ Varicose veins
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Insulin resistance
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Chronic fatigue / ME
- ☐ Long covid
- ☐ Autoimmune condition
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ MS
- ☐ Coeliac disease
- ☐ IBS
- ☐ Crohn's or colitis
- ☐ Reflux / GERD
- ☐ Gallbladder problems
- ☐ Fatty liver
- ☐ Kidney stones
- ☐ Asthma
- ☐ Sleep apnoea
- ☐ Epilepsy
- ☐ Migraine with aura
- ☐ Migraine without aura
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Bipolar
- ☐ PTSD
- ☐ ADHD
- ☐ Eating disorder
- ☐ Addiction
- ☐ Cancer
- ☐ Anaemia
- ☐ Low blood pressure
- ☐ None of these

If cancer — what type, when, and what treatment?

Operations, hospital stays and serious injuries

WHAT HAPPENED	YEAR	ANYTHING STILL REMAINING FROM IT

Do you have any of these in your body?

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Insulin pump
- ☐ Cochlear implant
- ☐ Metal plates, pins or screws
- ☐ Joint replacement
- ☐ Dental implants
- ☐ Amalgam fillings
- ☐ Root canals
- ☐ Braces or retainer
- ☐ Contraceptive coil
- ☐ Breast implants
- ☐ Surgical mesh
- ☐ Stent
- ☐ Tattoos
- ☐ Piercings
- ☐ None

All medication you take now — prescribed and over the counter

MEDICINE	DOSE	FOR HOW LONG	WHAT IT IS FOR

Do any of these apply?

- ☐ Antidepressants (SSRI/SNRI)
- ☐ Anti-anxiety / benzodiazepines
- ☐ Sleeping tablets
- ☐ Beta blockers
- ☐ Blood pressure medication
- ☐ Blood thinners
- ☐ Statins
- ☐ Steroids
- ☐ Antacids / PPI
- ☐ Antihistamines
- ☐ Painkillers regularly
- ☐ Antibiotics often
- ☐ Thyroid medication
- ☐ Diabetes medication
- ☐ Bisphosphonates
- ☐ Immunosuppressants

- [ ] Chemotherapy (past or present)
- [ ] None

Allergies — medication

Allergies — food

Allergies — other (latex, plaster, pollen…)

In your close family (mother, father, sisters, grandmothers), has anyone had:

- [ ] Breast cancer
- [ ] Ovarian cancer
- [ ] Uterine cancer
- [ ] Bowel cancer
- [ ] Other cancer
- [ ] Osteoporosis
- [ ] Heart disease
- [ ] Stroke
- [ ] Diabetes
- [ ] Thyroid disease
- [ ] Autoimmune disease
- [ ] Dementia or Alzheimer's
- [ ] Depression
- [ ] Addiction
- [ ] Early menopause (before 45)
- [ ] Blood clots
- [ ] High blood pressure
- [ ] None known

Is there an illness or a pattern that runs through the women of your family? Do you carry a fear about it?

Which practitioners do you currently work with?

- [ ] GP / family doctor
- [ ] Gynaecologist
- [ ] Endocrinologist
- [ ] Menopause specialist
- [ ] Naturopath
- [ ] Nutritionist
- [ ] Herbalist
- [ ] Acupuncturist
- [ ] Homeopath
- [ ] Osteopath / chiropractor
- [ ] Physiotherapist
- [ ] Massage therapist
- [ ] Psychotherapist
- [ ] Energy healer
- [ ] Ayurvedic doctor
- [ ] TCM practitioner
- [ ] None

11 Safety & Care In Our Work Together

So that what I offer you is right for your body, and never harmful.

> *These questions matter for breathwork, bodywork, ColorLight therapy, Tachyon and deep emotional release. Nothing here will exclude you from being met — it simply lets me adapt the work to you. Please answer all of them.*

Are you pregnant, or is there any possibility that you are pregnant? ☐ Yes ☐ No

Do you have epilepsy, a seizure disorder, or any sensitivity to flashing or coloured light? ☐ Yes ☐ No

If yes, please describe

Do you have a pacemaker, defibrillator or other implanted electronic device? ☐ Yes ☐ No

Do you have glaucoma, retinal disease, or have you had recent eye surgery? ☐ Yes ☐ No

If yes, please describe

Do you have uncontrolled high blood pressure, heart disease, an aneurysm, or a history of stroke? ☐ Yes ☐ No

If yes, please describe

Have you had surgery, a fracture or a serious injury in the last six months? ☐ Yes ☐ No

If yes, what and when

Do you have severe osteoporosis, a disc problem, or any area of your body that must not be pressed? ☐ Yes ☐ No

If yes, where

Do you have detached retina, severe asthma, or do you take blood thinners? ☐ Yes ☐ No

If yes, please describe

Do you have any open wounds, skin conditions, infections or fever at present? ☐ Yes ☐ No

If yes, please describe

Have you ever been hospitalised for a mental health crisis, or experienced psychosis, mania or dissociation? ☐ Yes ☐ No

If yes, when, and how are you now

Are you currently under psychiatric care, or taking medication for your mental health? ☐ Yes ☐ No

If yes, please describe

Are you at present having thoughts of harming yourself? ☐ Yes ☐ No

If yes, please tell me here — and please also speak to your doctor or your local emergency service. I will contact you personally before we begin.

Is there any movement, position, sound or kind of touch that your body cannot tolerate? ☐ Yes ☐ No

If yes, please describe

Do you have limited mobility, chronic pain, or do you need any adaptation to sit, lie or move comfortably? ☐ Yes ☐ No

If yes, please describe

Do you have any sensory needs — hearing, sight, sensitivity to sound, scent or crowds? ☐ Yes ☐ No

If yes, please describe

Is there anything at all that I should know before I work with your body or your energy field?

12 Eating, Digestion & Nourishment

Food is the medicine we take three times a day.

How do you eat?

- [ ] Omnivore
- [ ] Mostly plant based
- [ ] Vegetarian
- [ ] Vegan
- [ ] Pescatarian
- [ ] Ayurvedic
- [ ] Macrobiotic
- [ ] Mediterranean
- [ ] Low carb / keto
- [ ] Paleo
- [ ] Carnivore
- [ ] Raw food
- [ ] Gluten free
- [ ] Dairy free
- [ ] Sugar free
- [ ] No particular way

What time is your first food of the day?

Your last?

How many meals?

Do you snack between?

Please describe a typical day of eating — breakfast, lunch, dinner, snacks, drinks. Write it as it truly is, not as you think it should be.

How does eating happen for you?

- [ ] I cook most meals
- [ ] Someone cooks for me
- [ ] Mostly ready-made
- [ ] Eat out often
- [ ] Take-away often
- [ ] Standing up or in the car
- [ ] At a table, slowly
- [ ] In front of a screen
- [ ] Alone
- [ ] With family
- [ ] Rushed
- [ ] I forget to eat
- [ ] I eat at very different times each day

How often do you have these?

- [ ] Refined sugar daily
- [ ] Sweets after meals
- [ ] White bread / pasta
- [ ] Fried food
- [ ] Processed or packaged food
- [ ] Red meat
- [ ] Cured meat
- [ ] Dairy
- [ ] Cheese daily
- [ ] Eggs
- [ ] Oily fish
- [ ] Legumes
- [ ] Nuts and seeds
- [ ] Fermented food
- [ ] Cruciferous veg (broccoli, kale…)
- [ ] Flaxseed
- [ ] Soy, tofu, tempeh
- [ ] Bone broth
- [ ] Organic where possible
- [ ] Local and seasonal

Litres of water a day

From what container? (plastic, glass, steel)

Do you drink with meals?

Coffee — cups a day, and at what times

Tea — what kind, how much

Soft or energy drinks

Alcohol — what, how much, how often

Has it changed with menopause?

Do you use any of these?

- [ ] Cigarettes
- [ ] Vape
- [ ] Cannabis
- [ ] Nicotine pouches
- [ ] Recreational drugs
- [ ] Sleeping aids
- [ ] Painkillers for comfort
- [ ] None

Cravings — what calls you, and when?

- [ ] Sweet
- [ ] Salty
- [ ] Bread and carbs
- [ ] Chocolate
- [ ] Cheese
- [ ] Fried
- [ ] Sour
- [ ] Alcohol
- [ ] Coffee
- [ ] Late at night
- [ ] Mid afternoon
- [ ] Before my period
- [ ] When stressed
- [ ] When lonely
- [ ] When bored
- [ ] No strong cravings

How is your digestion?

- [ ] Bloating after meals
- [ ] Wind
- [ ] Reflux or heartburn
- [ ] Nausea
- [ ] Stomach pain
- [ ] Constipation
- [ ] Loose stools
- [ ] Alternating
- [ ] Daily bowel movement
- [ ] Every few days
- [ ] Undigested food
- [ ] Feeling heavy after eating
- [ ] Sleepy after eating
- [ ] Blood sugar crashes
- [ ] All is well

Foods you know you react to

Foods you avoid, and why

How is your relationship with food and with your body? Has there been a time of restricting, bingeing, dieting or struggle? Share only what you wish to — this is asked with care, so I know how to support you at the table and in the work.

Any dietary requirement for retreat (allergy, intolerance, preference)

13 Movement, Body & Touch

How you inhabit the form you were given.

What movement is in your life?

- ☐ Walking
- ☐ Running
- ☐ Swimming
- ☐ Cycling
- ☐ Gym / weights
- ☐ Yoga
- ☐ Pilates
- ☐ Qi Gong
- ☐ Tai Chi
- ☐ Dance
- ☐ Ecstatic dance
- ☐ Martial arts
- ☐ Hiking
- ☐ Gardening
- ☐ Team sport
- ☐ Physical work
- ☐ Nothing at present

How many times a week? | For how long? | How intense? | Hours a day sitting?

How does your body feel when you move?

- ☐ Strong
- ☐ Weak
- ☐ Stiff
- ☐ Flexible
- ☐ Painful
- ☐ Heavy
- ☐ Light
- ☐ Breathless quickly
- ☐ Tired after
- ☐ Energised after
- ☐ Afraid of injury
- ☐ Joyful

Where do you hold your tension?

- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Upper back
- ☐ Chest / heart
- ☐ Diaphragm
- ☐ Belly
- ☐ Lower back
- ☐ Hips
- ☐ Pelvis and womb
- ☐ Buttocks
- ☐ Legs
- ☐ Feet
- ☐ Hands
- ☐ Everywhere
- ☐ I don't feel my body much

Do you have ongoing pain? Where is it, how long has it been there, and what makes it better or worse?

How much do you like and accept your body as it is today?

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely

Your relationship with touch and being seen

- ☐ I love being touched
- ☐ Touch is difficult for me
- ☐ It depends who
- ☐ I receive massage regularly
- ☐ Rarely touched at all
- ☐ Comfortable undressed
- ☐ Uncomfortable undressed
- ☐ Comfortable in a group
- ☐ Nervous in a group
- ☐ I have done bodywork exchange before
- ☐ This will be my first time

Is there any part of your body you would prefer not to be touched, or anything you need in order to feel safe in touch?

Experience of these before?

- ☐ Massage
- ☐ Craniosacral
- ☐ Reiki
- ☐ Acupuncture
- ☐ Osteopathy
- ☐ Rebirthing / breathwork
- ☐ Holotropic breathwork
- ☐ Emotional release work
- ☐ Trauma therapy
- ☐ Tantric bodywork
- ☐ Yoni healing
- ☐ ColorLight therapy
- ☐ Tachyon
- ☐ Ito-Thermie
- ☐ None of these

14 Sleep & Rest

The most honest measure of a nervous system.

What time do you go to bed?

What time do you fall asleep?

What time do you wake?

Hours of sleep

How would you rate the quality of your sleep?

Terrible 1 2 3 4 5 6 7 8 9 10 Excellent

What happens in your nights?

- [ ] Hard to fall asleep
- [ ] Mind racing at bedtime
- [ ] Wake once
- [ ] Wake many times
- [ ] Wake at 3–4am
- [ ] Wake to urinate
- [ ] Wake in a sweat
- [ ] Wake with anxiety
- [ ] Wake with palpitations
- [ ] Cannot fall back asleep
- [ ] Wake too early
- [ ] Vivid dreams
- [ ] Nightmares
- [ ] Snoring
- [ ] Stop breathing (apnoea)
- [ ] Restless legs
- [ ] Teeth grinding
- [ ] Sleep well throughout

What helps you sleep?

- [ ] Nothing needed
- [ ] Melatonin
- [ ] Magnesium
- [ ] Herbal tea
- [ ] Valerian / passionflower
- [ ] CBD
- [ ] Sleeping tablets
- [ ] Antihistamine
- [ ] Alcohol
- [ ] Cannabis
- [ ] Reading
- [ ] Meditation
- [ ] Breathing
- [ ] Podcast or sound
- [ ] Weighted blanket
- [ ] Nothing works

Your bedroom and evening

- [ ] Completely dark
- [ ] Some light
- [ ] Cool
- [ ] Warm
- [ ] Quiet
- [ ] Noisy
- [ ] Phone by the bed
- [ ] Screens until sleep
- [ ] No screens for an hour
- [ ] TV in the room
- [ ] Share the bed
- [ ] Sleep alone
- [ ] Separate beds now
- [ ] Pets in the bed

Do you nap? When and for how long?

Do you work night shifts or cross time zones often?

How rested do you feel when you wake?

Exhausted 1 2 3 4 5 6 7 8 9 10 Fully restored

How is rest in your life?

- [ ] I rest without guilt
- [ ] I feel guilty resting
- [ ] I only rest when ill
- [ ] I take real days off
- [ ] I never truly stop
- [ ] I don't know how to rest
- [ ] I rest but don't feel restored

When did you last feel truly, deeply rested? What made it possible?

15 Stress, Nervous System & Emotional Landscape

What your body has been asked to carry.

How would you rate your stress at this time of your life?

None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable

Where does the pressure come from?

- ☐ Work
- ☐ Money
- ☐ My relationship
- ☐ Being single
- ☐ Children
- ☐ Teenagers leaving home
- ☐ Ageing parents
- ☐ Caring for someone ill
- ☐ My own health
- ☐ Grief
- ☐ Divorce or separation
- ☐ Legal matters
- ☐ Moving house
- ☐ Immigration
- ☐ Loneliness
- ☐ Body image
- ☐ Ageing
- ☐ The state of the world
- ☐ Not enough time
- ☐ Nothing in particular

Has any of this happened in the last two years?

- ☐ A death
- ☐ Divorce or separation
- ☐ New relationship
- ☐ Job loss
- ☐ Job change
- ☐ Retirement
- ☐ Moving country
- ☐ Moving house
- ☐ Children leaving home
- ☐ A serious diagnosis
- ☐ Surgery
- ☐ Accident
- ☐ Financial crisis
- ☐ Betrayal
- ☐ Estrangement
- ☐ A birth
- ☐ Something wonderful
- ☐ No major events

How present are these for you?

	NEVER	MILD	MODERATE	STRONG
Anxiety	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐
Low mood	☐	☐	☐	☐
Numbness or flatness	☐	☐	☐	☐
Anger or rage	☐	☐	☐	☐
Grief	☐	☐	☐	☐
Shame	☐	☐	☐	☐
Guilt	☐	☐	☐	☐
Fear of the future	☐	☐	☐	☐
Feeling invisible	☐	☐	☐	☐
Feeling not enough	☐	☐	☐	☐
Loss of identity	☐	☐	☐	☐
Loss of purpose	☐	☐	☐	☐
Overwhelm	☐	☐	☐	☐
Hypervigilance	☐	☐	☐	☐
Difficulty saying no	☐	☐	☐	☐
Perfectionism	☐	☐	☐	☐
Self-criticism	☐	☐	☐	☐
Loneliness	☐	☐	☐	☐
Peace and contentment	☐	☐	☐	☐

How does your nervous system usually respond under pressure?

- ☐ I speed up and do more
- ☐ I freeze and cannot act
- ☐ I shut down and withdraw
- ☐ I please and accommodate
- ☐ I get angry
- ☐ I cry
- ☐ I go quiet
- ☐ I overthink
- ☐ I eat
- ☐ I drink
- ☐ I clean or organise
- ☐ I exercise hard

- [ ] I dissociate or go blank
- [ ] I reach for others
- [ ] I isolate

Support you have or have had

- [ ] Psychotherapy now
- [ ] Psychotherapy in the past
- [ ] Counselling
- [ ] Coaching
- [ ] Group therapy
- [ ] Trauma therapy (EMDR, somatic…)
- [ ] Twelve-step programme
- [ ] Support group
- [ ] Spiritual guide
- [ ] Close friends
- [ ] Nobody, really

Have you experienced trauma, abuse, violence or loss that still lives in your body? Please share only what you feel ready to share. You may simply write 'I would prefer to speak about this in person'.

What in your life is still unfinished, unforgiven or unspoken?

How connected do you feel to other women right now?

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Deeply

16 Meditation, Practice & Inner Life

The thread that runs through everything I teach.

Do you meditate?

- ☐ Daily
- ☐ Several times a week
- ☐ Now and then
- ☐ I used to
- ☐ I have tried and stopped
- ☐ Never
- ☐ I want to begin

Which practices do you know?

- ☐ Silent sitting
- ☐ Mindfulness / Vipassana
- ☐ Osho Active Meditations
- ☐ Dynamic Meditation
- ☐ Kundalini Meditation
- ☐ Transcendental Meditation
- ☐ Mantra / japa
- ☐ Guided meditation
- ☐ Yoga Nidra
- ☐ Metta / loving kindness
- ☐ Zen
- ☐ Chakra meditation
- ☐ Walking meditation
- ☐ Prayer
- ☐ Chanting or kirtan
- ☐ Silence in nature
- ☐ None yet

How long have you practised?

How long do you sit?

At what time of day?

Breath and energy practice

- ☐ Pranayama
- ☐ Breathwork sessions
- ☐ Holotropic
- ☐ Wim Hof
- ☐ Coherent breathing
- ☐ Kundalini yoga
- ☐ Hatha yoga
- ☐ Vinyasa
- ☐ Yin
- ☐ Kriya
- ☐ Qi Gong
- ☐ Tantric practices
- ☐ None

What happens when you sit or breathe deeply? Do you meet stillness, restlessness, emotion, sleep, resistance, visions?

What is your background?

- ☐ Osho sannyas
- ☐ Tantra Essence
- ☐ Studied with Ma Ananda Sarita
- ☐ Other tantric school
- ☐ Buddhist
- ☐ Hindu / Vedic
- ☐ Christian
- ☐ Jewish
- ☐ Muslim
- ☐ Pagan / Goddess
- ☐ Shamanic
- ☐ Sufi
- ☐ Spiritual but no tradition
- ☐ Atheist / agnostic
- ☐ Raised religious, left it

How were you taught to think about God, the body, pleasure and sin as a child? Does any of it still hold you?

Which of these are part of your life?

- ☐ An altar at home
- ☐ Ritual or ceremony
- ☐ Oracle or tarot cards
- ☐ Astrology
- ☐ Journalling
- ☐ Moon cycle awareness
- ☐ Women's circles
- ☐ Plant medicine
- ☐ Cacao ceremony
- ☐ Ayahuasca
- ☐ Psilocybin
- ☐ Kambo
- ☐ Fasting
- ☐ Silent retreat
- ☐ Pilgrimage
- ☐ Sound healing
- ☐ Energy healing
- ☐ None

If you have worked with plant medicine — what, when, and how did you integrate it?

What does the sacred mean to you? When do you feel closest to it?

Which retreats or trainings have you attended before?

- ☐ None
- ☐ A yoga retreat
- ☐ A meditation retreat
- ☐ A tantra workshop
- ☐ A women's retreat
- ☐ A silent retreat
- ☐ A plant medicine retreat
- ☐ A breathwork intensive
- ☐ A therapy intensive
- ☐ Many

If yes — which, and with whom?

17 Intimacy, Sexuality & Relationship

Held in complete confidence. Answer only what you wish to.

> *This is the most tender territory, and also where menopause changes most. Nothing here is required. What you share helps me meet you with precision and care.*

Your relationship life right now

- ☐ Married
- ☐ Long partnership
- ☐ New relationship
- ☐ Dating
- ☐ Single by choice
- ☐ Single, would like a partner
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Polyamorous
- ☐ Long distance
- ☐ Living apart
- ☐ It is complicated

If partnered — for how long?

Does your partner know you are coming to this work?

How satisfied are you in your intimate life?

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Deeply

What has changed in your body and desire?

- ☐ Libido has fallen
- ☐ Libido has risen
- ☐ Desire comes and goes
- ☐ Desire is there, arousal is slow
- ☐ Dryness
- ☐ Pain with penetration
- ☐ Burning or tightness
- ☐ Loss of sensation
- ☐ Orgasm harder to reach
- ☐ Orgasm feels different
- ☐ Orgasm is stronger now
- ☐ Bleeding after sex
- ☐ Loss of interest in touch
- ☐ Craving touch
- ☐ No change

Your intimate practice

- ☐ Active with a partner
- ☐ Self-pleasure regularly
- ☐ Self-pleasure rarely
- ☐ Never self-pleasure
- ☐ Use lubricant
- ☐ Use vaginal moisturiser
- ☐ Use vaginal oestrogen
- ☐ Use toys
- ☐ Practise tantra alone
- ☐ Practise tantra with partner
- ☐ Celibate by choice
- ☐ Celibate not by choice

How was your sexuality shaped — your first experiences, what you were told, what you learned to hide or perform?

Have you experienced sexual trauma, coercion or violation? Only if and as much as you wish. You may write 'in person'. Please also tell me what you need in order to feel safe in this work.

What would you love to reclaim, or discover for the first time, in your sexual and creative energy?

In group work, what feels true for you?

- ☐ Comfortable with nudity
- ☐ Not comfortable with nudity
- ☐ Comfortable with partner exercises
- ☐ Prefer to work alone
- ☐ Happy to be touched by others
- ☐ Prefer not to be touched by others
- ☐ I will say no if I need to
- ☐ I find it hard to say no
- ☐ I need to be asked first, always

18 What You Put On Your Skin & Use At Home

The invisible daily dose. Brands and names are very welcome.

> *Many everyday products contain substances that behave like hormones in the body — parabens, phthalates, BPA, triclosan, synthetic fragrance, some sunscreens. I am not here to alarm you, only to see the whole picture.*

Your daily and weekly products

PRODUCT	BRAND / NAME YOU USE	HOW OFTEN
Facial cleanser		
Moisturiser / face cream		
Serum or oil		
Sunscreen		
Foundation and make-up		
Lipstick / lip balm		
Deodorant or antiperspirant		
Perfume or body spray		
Shampoo		
Conditioner		
Hair styling products		
Hair dye or bleach		
Hair straightening treatment		
Body wash / soap		
Body lotion		
Hand cream		
Nail polish / gel / acrylics		
Intimate wash		
Lubricant		
Menstrual products (pads, tampons, cup)		
Essential oils		
Self-tan		
Anti-ageing / retinol		

Cosmetic treatments

- ☐ Botox
- ☐ Fillers
- ☐ Chemical peels
- ☐ Laser
- ☐ Microneedling
- ☐ Permanent make-up
- ☐ Hair removal — waxing
- ☐ Hair removal — laser
- ☐ Sunbeds
- ☐ Spray tan
- ☐ Regular facials
- ☐ Regular manicures
- ☐ None

At home, do you use:

- ☐ Conventional cleaning sprays
- ☐ Bleach
- ☐ Laundry detergent (conventional)
- ☐ Fabric softener
- ☐ Dryer sheets
- ☐ Air fresheners / plug-ins
- ☐ Scented candles
- ☐ Incense
- ☐ Non-stick pans
- ☐ Aluminium pans or foil
- ☐ Plastic food containers
- ☐ Cling film
- ☐ Microwave food in plastic
- ☐ Plastic water bottles
- ☐ Dry cleaning
- ☐ Insect spray
- ☐ Garden pesticides
- ☐ Natural / eco products mostly
- ☐ Fragrance-free products

And these?

- ☐ Handle till receipts often
- ☐ Live near mobile mast
- ☐ Live near heavy traffic
- ☐ Sleep with phone beside head
- ☐ Long hours on laptop on lap
- ☐ Smoke or live with a smoker
- ☐ Wifi router in bedroom
- ☐ Live near farmland that is sprayed
- ☐ None of these

How much attention have you already given to reducing chemical exposure?

None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ A great deal

Is there anything you use daily that I have not asked about?

19 Your Days, Your Habits, Your Joy

Who you are when nobody needs anything from you.

Walk me through an ordinary day of yours, from waking to sleeping.

Hours a day on screens for work

Hours a day on your phone

Hours on social media

Which of these fill your days?

- ☐ Work I love
- ☐ Work I endure
- ☐ Caring for others
- ☐ Housework
- ☐ Studying
- ☐ Volunteering
- ☐ Building something
- ☐ Looking for work
- ☐ Retired
- ☐ On sick leave
- ☐ Too much to do
- ☐ Not enough purpose

What do you do for pleasure? Tick all that are truly yours.

- ☐ Reading
- ☐ Writing
- ☐ Painting or drawing
- ☐ Pottery or crafts
- ☐ Sewing or knitting
- ☐ Singing
- ☐ Playing music
- ☐ Dancing
- ☐ Photography
- ☐ Cooking
- ☐ Baking
- ☐ Gardening
- ☐ Being in nature
- ☐ Swimming in the sea
- ☐ Hiking
- ☐ Cycling
- ☐ Animals and pets
- ☐ Travelling
- ☐ Learning languages
- ☐ Theatre or cinema
- ☐ Museums and art
- ☐ Concerts
- ☐ Time with friends
- ☐ Time alone
- ☐ Podcasts
- ☐ Board games
- ☐ Sport
- ☐ Sauna or bathing
- ☐ Nothing at the moment

What did you love as a girl that you no longer make time for?

Your social life

- ☐ Close friends nearby
- ☐ Friends far away
- ☐ A community I belong to
- ☐ A women's circle
- ☐ Mostly family
- ☐ Mostly colleagues
- ☐ I feel isolated
- ☐ I prefer solitude
- ☐ I long for deeper friendship
- ☐ I have people but feel unseen

When did you last laugh until you cried?

When did you last dance?

Your rhythms

- ☐ Morning person
- ☐ Night person
- ☐ Very structured days
- ☐ No structure at all
- ☐ Always in a hurry
- ☐ Slow and steady
- ☐ Constantly interrupted
- ☐ I schedule my rest
- ☐ I say yes to everything
- ☐ I protect my time

What depletes you most? And what genuinely restores you?

How much pleasure — of any kind — is in your life at present?

Almost none ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 An abundance

20 Your Intention

Why now, and what is calling you.

Why now? What made you fill in this form on this particular day?

What is the greatest difficulty you are facing at this moment?

What are you ready to release — a role, a fear, a story, a person, a way of being?

What do you long to receive?

If this transition is an initiation and not an ending, what do you sense it is initiating you into?

What frightens you about this passage?

Imagine yourself one year from now, having received everything this work can give. What is different? What would you be doing on an ordinary Tuesday?

What do you most want support with?

- ☐ Physical symptoms
- ☐ Sleep
- ☐ Energy and vitality
- ☐ Weight and body
- ☐ Mood and emotions
- ☐ Anxiety
- ☐ Grief
- ☐ Anger
- ☐ Sexuality and desire
- ☐ Intimacy with my partner
- ☐ Confidence and voice
- ☐ Purpose and direction
- ☐ Spiritual deepening
- ☐ Connection with women
- ☐ Self-love
- ☐ Boundaries
- ☐ Creativity
- ☐ Rest

What do you need from me in order to feel safe, seen and able to open?

Is there anything you have never told anyone that feels important for me to know?

Do you have questions for me?

Anything else you would like to add

21 Consent & Confidentiality

Your words are held in trust.

> *Everything you have written is confidential and is seen only by Amma Usha Regina, and where necessary by the facilitators supporting your care. It is stored securely, used solely to prepare and adapt your sessions or your retreat, and is never shared or sold. You may ask for it to be deleted at any time by writing to me.*

I confirm that what I have written is true and complete to the best of my knowledge.	☐ Yes	☐ No
I consent to my information being stored and used to prepare and adapt my sessions or retreat.	☐ Yes	☐ No
I consent to relevant health and safety information being shared with the facilitators caring for me.	☐ Yes	☐ No
I consent to my birth data being used to prepare an astrological chart for my reading.	☐ Yes	☐ No
I understand that this work is complementary and does not replace medical diagnosis or treatment, and that I remain responsible for my own medical care.	☐ Yes	☐ No
I agree to inform Amma Usha Regina of any change in my health before my session or retreat begins.	☐ Yes	☐ No
I consent to photographs or film in group settings being used for MenoDawn's communication. (You may say no; it changes nothing.)	☐ Yes	☐ No
I would like to receive the MenoDawn newsletter and news of future gatherings.	☐ Yes	☐ No

Full name (as signature)	Date	Place

> *Thank you for the time and the truth you have given to these pages. Please save this file with your name — for example MenoDawn-Questionnaire-YourName — and send it back to me. Everything you have written will be read with care before we meet.*

Thank you.

You have just given words to things many women carry in silence.
That in itself is the beginning of the work.

Please save this file with your name and send it back to me.

I will read every word before we meet.

Amma Usha Regina

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