



# Noni Family Wellness Movement



and

## THE HEALTH AWARENESS CENTRE

### PERSONAL ASSESSMENT FORM

#### I. PERSONAL HISTORY

Form No : . . . . .

Date : . . . . .

Name : Mr.\Ms. . . . .

Age . . . . . Years

Weight . . . . . Kgs

Height . . . . . Inches

Occupation : . . . . .

Married

Single

Address:

Residence

Office

.....	.....
.....	.....
.....	.....
.....	.....

Tel : . . . . .

E-mail : . . . . .

What are your special interests\ hobbies?

.....

Are you a member of any group or social organization?

.....

How did you learn about us,? (Please provide Reference)

.....

Why are you doing this programme ?

To stay fit     Cure an illness     Learn more about health

Lunch Services\ Food Programme     Others (Please Specify) . . . . .

What is your opinion about your health?

Almost always healthy     Usually healthy, fall sick occasionally

Fall sick frequently     Chronically ill

**II. DIETARY HISTORY**

**(A) FOOD HABITS**

VEGETARIAN

NON- VEGETARIAN

if Non- Vegetarian how many times a week do you eat ? What are your preferences?  
(e.g. chicken, fish etc)

.....  
 .....

What is your normal eating pattern?

	TIME	ITEMS AND QUANTITIES (eg 1 glass milk, 2slices toast)
Breakfast		
LUNCH		
SNACKS		
DINNER		

On a weekly average where do you eat and how often?

Home ..... Parties .....  
 Restaurants ..... On the run .....

Tick what you like of the following foods. How much do you eat in a day?

Fruits .....  Vegetables .....  Fried food .....  
 Fast food .....  Rich or Spicy food .....  Sweets Desserts .....  
 Baked items (bread, cakes, biscuits) .....  
 Dairy products (milk, ice-cream, cheese..) .....

How many (cups\glasses) do you drink in a day? (Please write with\without sugar)

Tea ..... Coffee ..... Fruit juice .....  
 Alcohol ..... Aerated drinks ..... Water .....  
 Why? .....

When would you prefer your heaviest meal?  Morning  Afternoon  Evening

Do you eat because (Tick all that apply)  For religious reasons

You are hungry  For a pick -me-up  From frustration  To be sociable

From routine\habit  Have always been eating  Response to peer pressure

To avoid ulcers\acidity  Good Health  Enjoy eating  Never thought about it

**(B) CURRENT MEDICAL STATUS** (Tick all that apply)

- Healthy, Normal, Active
- Heart ailments  Diabetes  BP (High, Low)  Overweight
- Cholesterol  Arthritis  Constipation  Allergies
- Underweight  Asthma  Chronic cold, Fever  Menstrual Discomfort
- Hysterectomy  Osteoporosis  Headaches \Migraines  Dental trouble
- Back problems  Spondylosis  Stomach ailment  Skin
- Kidney ailments  Cancer  Hormonal imbalance  Others

Any Major operation surgery undertaken?

.....

Mention history of major illnesses if any (typhoid, jaundice, malaria)

.....

What treatment did you follow?

.....

History of Motherhood (Conception, Pregnancy, Child birth)

.....

**(C) MEDICAL HABITS**

(i) What medications do you take?

MEDICINE	DOSAGE	SINCE WHEN	MEDICINE	DOSAGE	SINCE WHEN
BP			Aspirin		
Oral Contraceptives			Sleeping pills		
Antacids			Antibiotics		
Diuretics			Vitamins		
Insulin\Oral Drugs			Laxatives Natural\ chemical		
Heart Drugs			(Homeopathy\ Unani\Ayurved)		

Describe the circumstances\reasons for starting the medication?

.....  
.....

Apart from medication, is there anything else you do when you are ill? (eating habits, rest, etc.)

.....  
.....

**(D) PERSONAL HABITS**

Smoking (Cigarettes\Day) . . . . . Tobacco Chewing . . . . .

Alcohol (Drinks\Week) . . . . .

Exercise	Type (eg Yoga)	Duration (eg 1 hour)	How often (eg Twice a week)
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.....	.....	.....	.....
.....	.....	.....	.....

Desk job (Hours\ Day) . . . . . Computer job (Hours\Day) . . . . .

Outdoor Activity (Hours\Day) . . . . . Sunning . . . . .

Creative Activities . . . . . Deep Breathing . . . . .

Rest and Relaxation . . . . . Meditation( Times \Week) . . . . .

Sleep (Hours \ Night) . . . . . Sleep Rested \Disturbed . . . . .

When does your highest energy level occur?

Late in the day. . . . . Following Meals. . . . . Late at night . . . . .

First thing in the morning . . . . . Energetic all day. . . . .

What are your expectations from this Wellness program?

.....  
.....

What is your opinion about good health?

.....  
.....

### III. OVERALL HEALTH PERSPECTIVE

Check each symptom, according to its severity

0 : Never Occurring

1 : Mild, Occasionally

2 : Moderate, Once a week

3 : Severe, Frequently Occurring

Add the Numbers, and Give your total score

No.	SYMPTOMS	I	II	III	IV	V	VI
	Date						
1.	Tired all the time						
2.	Hungry between meals or at night						
3.	Wake up after a few hours of sleep						
4.	Fearful (Overwhelmed by people, place, things)						
5.	Magnify insignificant details						
6.	Eat junk foods						
7.	Consume alcohol						
8.	Drink more than 3 cups of coffee \tea\colas daily						
9.	Crave for sweets\soda\coffee between meals or mid-afternoon						
10.	Can't work well under pressure						
11.	Lack of energy						
12.	Depressed						
13.	Insomnia						
14.	Indecisive						
15.	Cannot concentrate						
16.	Poor memory						
17.	Worry frequently						
18.	Low self image						
19.	Insecurity						
20.	Highly emotional						
21.	Moody						
22.	Cry easily or feel like crying inside						
23.	Fearful (Overwhelmed by people, place, things)						
24.	Fits of anger\ temper						
25.	Headaches						

No.	SYMPTOMS	I	II	III	IV	V	VI
26.	Sleepy during the day						
27.	Drowsy after meals						
28.	Can't get started in the morning						
29.	Eat when nervous						
30.	Allergies						
31.	Fatigued, relieved by eating						
32.	Get shaky inside if hungry						
33.	Suicidal thoughts \tendencies						
34.	Bad dreams						
35.	Cold, sweaty hands\feet						
36.	Trembling hands						
37.	Bleeding gums						
38.	Easily bruised						
39.	Uncoordinated-drop\bump into things						
40.	Muscle twitching\cramps						
41.	Phobias						
42.	Frequent urination						
43.	Stomach cramps\nervous stomach						
44.	Asthma\hay fever\skin\rash						
45.	Irritable before meals						
46.	Feel faint if meal is delayed						
47.	Bored						
48.	Palpitations						
49.	Ulcers\gastritis \ chronic						
50.	Indigestion\abdominal bloating						
51.	Blurred vision						
52.	Dizziness\giddiness\light headedness						
53.	Aware of breathing heavily						
54.	Excessive Sweating						
55.	Excessive thirst						
56.	Drastic weight change						
57.	Nausea						
Total Score							