QUESTIONNAIRE

No.

Date : ....

Date of Birth :

Height : Blood Group :

Weight : Age :

Name : ....

Hair Falling	Yes / No	Dandruff	Yes / No
Wearing Glasses	Yes / No	Bulged Eyes	Yes / No
Pigmentation around Eye	Yes / No		
Ear - External Defects	Yes / No	Ringing Inside Ears	Yes / No
Any Ear Surgery	Yes / No	Problem During Younger Age	Yes / No
Tonsil Problem	Yes / No	Rough Voice	Yes / No
Tooth (some teeth are removed)	Yes / No	Replaced	Yes / No
Root Canal Treatment	Yes / No	8 7 6 5 4 3 2 1 21 22 23 24 25 26 27 28	
Tooth Infection	Yes / No		
Irregular Teeth	Yes / No	48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38	
Tongue (Recurrent Ulcers)	Yes / No	Pigmentation of Tongue	Yes / No
Neck Swelling Present	Yes / No	Any scar on the neck	Yes / No
Pain in neck region while drinking or swallowing	Yes / No		
Head Ache Present	Yes / No	Front Side, Back Side, Sides Rt/L, All Area	
Relieved by Ointment, Tablets		Sinus Head Ache	Yes / No
Nose Block Present	Yes / No	Right Side, Left Side, Both Sides, Alternate Side	
Sneezing Present	Yes / No	Bleeding Nose Present	Yes / No
Pigmentation around the nose present	Yes / No	Chest Pain Present	Yes / No
Breast Pain	Yes / No	Surgery, Glands, Swelling	
Breathlessness While Walking / Climbing Stairs / Heavy Work Only			
Palpitation Chest	Yes / No		
B.P.	High BP / Low BP / Normal	Swelling of Face / Legs / Hand	Yes / No
Distended Belly	Yes / No		

Urine – Urinary Infection / Diabetes

Motion – As soon as waking up / after some drinks / Irregular / Constipation / Frequent stools

Sleep – Sufficient / Exess / Not Satisfied / No Sleep at all

Afternoon Sleep 10 minutes / ½ Hr. /1 Hr. / more than 1 hour

Wake-up timing : ....am, Go to sleep at ....pm, Night supper at ....pm

Laziness Excess / Less

Tension – No tension / Excess tension / O.K. / Always tension / sufficient as and when necessary

Any Surgery – Under went : Uterus / Tonsils / Sinus / Caesserian (Delivery Surgery) / Appendix, Piles, Breast, Tubectomy (Birth Control)

While eating food I do – Watching TV / Listening Radio / Reading / Tasting Food / Talking to others or Phone

Consumption of Water – Early morning / During tiffin / During lunch / During supper / Before bed

Quantity of water consumed : Each time .... Total / Day ....

The taste you like more – Bitter / Sweet / Sour / Hot / Saltish

Excess gas releived from – Stomach / Anus Acidity / Ulcer / Indigestion Yes / No

Muscle Spasm Present / No Which Area Neck / Back / Hip

Pain Area Present / No Neck / Back / Low Back / Numbness / Irritation

Skin — Moles : If Yes – Face / Neck / Chest / Abdomen / Hand / Finger / Leg / Foot

Pigmentation — Yes / No : If Yes – Face / Neck / Chest / Abdomen / Hand / Finger / Leg / Foot

Scar — Yes / No : If Yes – Face / Neck / Chest / Abdomen / Hand / Finger / Leg / Foot

Varicose Vein Yes / No Hand / Hip / Leg / Calf

Fissure (Cracks / Dryness) — If Yes – Foot / Hand / Fingers / Anal Regeion / Urinary Passage

Nails Problem — Yes / No Hand Fingers / Toes - Big Toes Rt/Left / Irregular, Ingrowing Nail,
Hard, Pigmentation, Slow Growth / Fast Growth / Breaks Faster

Sweating : Normal / Excess / No Sweating / Some Places Only

Cold Tolerance Tolerable / Not Tolerable Heat Tolerance Tolerable / Not Tolerable

Drinking : Coffee / Tea / Milk / Others .... (How many times) ....

Which is dominating in mind : Fear / Worry / Angry / Hatred

Birth Star .... Rasi .... Lagna ....

Flower you like .... Colour you like ....

If tensed what gives you relief : Shouting / Listening to Radio, Music / Watching T.V. / Reading Books /
Nothing / Others ....

Family History of Diabetes, Thyroid, BP, Asthma / Allergy : Father / Mother / Brothers / Sisters

Appetite : Sufficient / Not Sufficient / Excess Habit of Fasting / Not Fasting

Can you tolerate hunger Yes / No

How do you drink water : Just Gulping / Slow / Enjoy Drinking

Educational Status : School .... College ....

House Wife / Partly Employed / Trying for Job / Business

Name ....

Wife / Husband / Father ....

Address ....

....

Phone .... Mobile .... Email...

Medicines which I take daily : 1. 2.
3. 4.