Health and Habits Review

Date: Name: Age Email (Print)

Home# Cell# Single/ Married/ Other Children: Boys Girls

Living with Pets owned Leisure time activities

Occupation I knew about the classes from

- **Why do I want to do these classes?**

Anxiety	Asthma	Allergies	Acidity	Anger	Addictions
Back pain	Concentration/Focus	Cancer survivor		Chronic pains	
Compulsive/Negative thoughts		Depression	Diabetes	Drug abuse	Fatigue
Fears/ Phobias		Fear of dental work		Fibromyalgia	Grief
Headaches	Hypertension	Infertility related stress		Insomnia	
Lack of willpower		Migraine	Obesity	Panic attacks	
Relationship stress		Smoking/tobacco		Stress	
Stuttering	Others.....				

- **Past major illnesses or surgeries** (What and when)
  Self Father Mother
- **Past traumas** (Mental and Physical)
  - How are they affecting my current life?
- **Stress level on a scale of 1 to 7**. (A little is 1. Falling apart is 7)

  I get most stressed when….
- **My visits to primary care doctor:** # of times a year Last annual physical exam was on
- **My visits to therapist:** # of times a year Last visit was on
- **Height** (inches) **Weight** (lbs) **BMI** (Normal = 18.5 to 24.9)
- **Girth** (inches) (Normal for men = 40 inches, Women = 35)
- **Current medications** **Supplements**

- **Sleep**
  Time to bed Minutes/Hours spent to get sleep Hours of sleep

  What do I do to get sleep: Read / Watch TV / Listen to music / Other ……...

  # of times sleep is disturbed Tossing and turning Bad dreams Sleep apnea

  Waking up time How do I feel on waking up? Medicines/ Supplements for sleep?.....

- **What I eat and drink most days**

  Breakfast Lunch Dinner

  Snacks Hot drinks Water consumed (Cups)

- **Bowel movement** Constipation? No /Yes Passing stool - Once a day/Twice

- **Physical exercise being practiced**

	Gym exercise	Walking	Yoga	Other
# of Days a week	….....…	……..	….....	…….
Minutes per session	….....	….....	….....	…….

- **How is my interaction/relationship with**

  Spouse/ partner Children

  People at work Who is my primary support now?

- **Current worries** Relationships Job Finances Others……

- **Recently lost a family member or close friend?** No / Yes Feeling the grief now? No / Yes

- **How do I manage my stress now?**

  Comfort foods Getting busy Smoking Alcohol Others (Specify) ……..

- **Relaxation or Meditation practices**

  I have been regularly practicing since

  I practiced these techniques in the past but discontinued Yes

- **Religious habits**

  I pray Yes / No I chant God's name Yes / No

- **My memories**

  Happy ones

  Unhappy ones

- **Other comments**

- **Who is responsible for my problems?**

  Myself? Why?

  Others? Who? Why?

- **My Top Goals**

  1. ….....

  2. ….....

  3. ….....

  To achieve these goals, I commit myself to learn and practice **New techniques, develop them into habits** and gradually change my old habits**.**