Health and Habits Review

Date Name e-mail (PRINT):

Home# Cell#:

I learned about these classes from

These classes were recommended by

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

Insomnia	Anxiety	Stress	Depression	
Hypertension	Diabetes	Acidity/ heartburn	Obesity	
Back pain	Migraine	Fibromyalgia	Headaches	
Smoking	Panic attacks	Focus/ Concentration	Grief	Anger
Cancer survivor	Others			

- **Past major illnesses or surgeries** (What and when)
  Self

  Father Mother
- **Past traumas** (if any)
- **Stress level** (On a scale of 1 to 10. 1 is a little. 10 is at breaking point) .....
  It is mainly due to
- **I had my last annual physical exam on** .....**I visit my doctor** .....times a year.
- **Height** **Weight** **BMI**
- **Daily medications**
- **Daily supplements**
- **Sleep**
  Time to bed?

  What do I do, to get sleep?
  Reading Watching TV Listening to music Other.....

  How long does it take to get sleep?

  # of times sleep is disturbed and the reasons

  Quality of sleep?
  Bad dreams Tossing and turning Sleep apnea Other.....

  Hours of sleep Waking up time How do I feel on waking up?
- **What do I eat and drink daily**
  Breakfast

Lunch

Dinner

Snacks

Drinks

Water consumed - Cups (one cup is 8 Oz) per day .....

- **How many times to the toilet?** Once Twice **Constipation?** No Yes

- **Physical Exercise being practiced**

	Gym exercise	Walking	Yoga	Other
Days a week	.....	.....	.....	.....
Minutes/ session	.....	.....	.....	.....

- **How is my interaction**

  With my spouse/ partner/ family?

  With the people at work?

- **Relaxation or Meditation practices**

  I have been practicing ..... since.....

  I practiced the following techniques in the past but discontinued

- **Religious habits** (if any)

  I pray Yes No

  I chant God's name Yes No

- **Other comments**

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

  Myself? Why?

  Others? Who? Why?

- **I want to learn new skills and develop them into habits to achieve the FOLLOWING GOALS**

1. .....
2. .....
3. .....