

| Beating Diabetes Program: Client information | |
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| **Contact Details** | |
| **Email this to dr.ramaprasad@punarnava.org or upload this to the message box on vaidyagrama.com/BeatingDiabetes page** | |
| Full name: |  |
| Email address: |  |
| Phone number: |  |
| Age, gender: |  |
| Postal address: |  |
| Work, role, family, social: |  |
| What is your role at work?: |  |
| How many hours do you work?: |  |
| Do you do night shifts? How often?: |  |
| How many are in your family?: |  |
| Describe your role in your family: |  |
| Describe your social life: |  |
| Write down five topics/things/events that you find hard to deal with, at work and in other areas of life, currently: |  |
| How are you dealing with them?: |  |
| **Diabetes information** | |
| What were the initial signs?: |  |
| When did you test positive for type 2 diabetes?: |  |
| What was your exact result, then?: |  |
| Was your diagnosis accidental?: |  |
| **Health** | |
| What are other diagnosed conditions you have? When? Symptoms? Medications? Treatments?: |  |
| What are the undiagnosed conditions you have? When? Symptoms? Medications? Treatments?: |  |
| How often does your sleep get disturbed, and why?: |  |
| How often does your fitness program get disturbed, and why? |  |
| **Tests** | |
| What are your current blood sugar levels?: |  |
| What are your current urine sugar levels?: |  |
| **Treatment and Diet** | |
| What are the medications you are on currently?: |  |
| What is the diet you are on currently?: |  |
| What are the new lifestyle activities you have adapted? What are the results? |  |
| Tell us about your typical day's meals, snacks and drinks in detail.: |  |
| How many soft drinks do you have, daily?: |  |
| Do you have any food cravings? How often? What do you eat?: |  |
| **Fitness** | |
| How many naps (short sleep) or rests do you need daily during the daytime?: |  |
| How many hours of exercise do you do per week?: |  |
| What type of exercises and duration of each of them?: |  |
| When (morning, evening etc) do you do your exercises mostly?: |  |
| How long do you sweat during your exercises?: |  |
| How many times can you do an average block of stairs (going up and down) in 10 minutes?: |  |
| How do you feel after that?: |  |
| **Aptitude** | |
| Do you think you need to boost your overall health?: |  |
| Why are you interested in our RD2 program?: |  |
| Are you interested in upgrading your health and wellness to a more effective lifestyle?: |  |
| Are you in a position to upgrade to adopt a more effective lifestyle?: |  |
| What sort of moral support you might get from your family, with your wellness program, during and after this retreat? What type? Which areas? How long?: |  |
| **General** | |
| What is your energy level, out of 10?: |  |
| How long do you sleep?: |  |
| How do you feel when you wake up?: |  |
| Are you generally improving, getting worse, or going steadily with your health?: |  |
| Do you know ours is a natural health retreat?: |  |
| Have you had any health issues that required immediate hospital visit?: |  |
| Are you doing it at your will?: |  |
| Attachment: 1) diet, 2) herbs, supplements, 3) natural medications, 4) allopathic medications, and 5) treatments:  Do you snore?: |  |
| **Important** | |
| Do you know that the nearest emergency hospital is 60 minutes away?: |  |
| Once we receive it, we'll respond in 48 hours. |  |
| **Your goals** | |
| General: |  |
| Specific: |  |
| Anything else: |  |
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