

| 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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