General Health Questionnaire.

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Please answer the following questions in a descriptive manner after careful analysis and recollection of previous experiences and happenings. Print this and fill it with cool mind and bring it over on your first appointment.

1. Describe your main suffering?

2. What other physical sufferings do you have in your body?

3. What mental sufferings / feelings do you have associated with your physical sufferings?

4. What exactly do you feel when you are at your worst?

5. When did it all start? Can you connect it to any past event or disease?

6. Which time of the day you are worst?

7. What are the things which aggravate your suffering and which are those which ameliorate the same?

8. Do your think your sufferings have relation to any external stimuli (like, change of place, weather etc.) or any internal biological changes in the body, like, menses (in females)?

9. When do you feel better, during hot weather or cold weather, humid or dry weather?

10. Describe your general mental set up? Are you Moody, Arrogant, Mild, Agreeable Changeable, Nervous, Suspicious, Easily offended, Quiet, Arguing, Irritating, Lazy etc.

11. How do you feel before or during a thunderstorm?

12. Do you like being consoled during your tough times?

13. Are you sensitive to external stimuli like smell, noise, light etc?

14. Do you have any typical habit or gesture like nail biting, causeless weeping, talking to one self etc?

15. How do you feel about your friends, family, your children and especially your husband / wife?

16. What are your fears and do you dream of any situation repeatedly?

17. What do you crave for in food items and what are your aversions?

18. What is your skin type, oily, dry, shiny or rough?

19. Do you notice any unusual discoloration or hyper pigmentation of skin, around eyes, knees, arms, forehead or some other parts of your body?

20. How is your thirst: Less, Normal or Excessive?

21. How is your hunger: Less, Normal or Excessive?

22. Is there any kind of food which your body can’t stand?

23. Is your sweat normal, less or more? Where do you sweat more: Head, Trunk or
axillae or limbs?

24. How is your bowel movement and stool type?

25. How well do you sleep? Do you have a particular posture of sleeping?

26. Do you think you are able to satisfy your sexual desires in general?

27. What peculiar or strange sensation do you have in any part of your body at times? Do
you sometimes feel ‘ as if…..’ in some part of the body?

28. What medications have been taken earlier by you to treat the diseases and do you
have any particular symptom surfacing after the medication?

29. What major diseases are running in your family?

30. How many hours do you sleep each night on average?

31. Do you exercise routinely, weekly daily or not at all?

32. Describe, how rate yourself health wise?

Very Bad **OK** **Very Good**

| | | | | | | | | |
1 2 3 4 5 6 7 8 9 10

33. How would you rate your energy level?

Very
OK
Very
Bad
Good

| | | | | | | | | |

1 2 3 4 5 6 7 8 9 10

34. How confident you are that you can changes to life style which can help your health?

Not at all
Very
Confident
Confident

| | | | | | | | | |

1 2 3 4 5 6 7 8 9 10

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