

Wellness Ambassador Program Health Log

Name & Birth Date: (D/M/Y):

Job Description:

Tel/WhatsApp No.

Email:

Does any of the following affect you? Yes / No. (Please Tick and circle what is applicable, 'O for often, R for Rarely, N' for Never) :

SYMPTOMS:

The change after the workshop :

- 1. Fever O / R / N
- 2. Headache O / R / N
- 3. Back Pain O / R / N
- 4. Joint Pain O / R / N
- 5. Cold/Cough O / R / N
- 6. Nausea O / R / N
- 7. Indigestion O / R / N
- 8. Allergy O / R / N
- 9. Dizziness O / R / N
- 10. Any other: _____

LIFE STYLE:

The change after the workshop:

- 1. Erratic food habits O / R / N
- 2. Tension or Anxiety O / R / N
- 3. Work Stress O / R / N
- 4. Lack of Sleep or Rest O / R / N
- 5. Polluted Environment O / R / N
- 6. Conflict or Disputes O / R / N
- 7. Any other: _____

Rate in a score of 1 to 05 to describe the improvement in you :

1. Have you become more friendly? =
2. Have you become more engaged and active? =
3. Are you more mindful in your food habits? =
4. Are you more in touch with your feelings? =
5. What extent you have gained insights? =