GRAHANI ASSESMENT SCALE

The role of *Pathya Ahara* (wholesome diet) is very important in maintaining good health, when not followed leads to impairment of digestive fire causing certain disease, among them one is *grahani roga*(disease anywhere lying between the stomach and intestines). The questionnaire has been framed in a manner which helps us in diagnosing *grahani roga***.** Hence *grahani assesment scale was* prepared. All personal data and information collected in this survey will be treated with the utmost confidentiality. Rest assured that the information you provide will be used strictly for academic purposes.

1. Name (optional):
2. Age:
3. Gender:
4. Occupation:
5. Locality: urban/rural
6. WhatsApp contact number:
7. Email id:
8. Religion(optional):
9. **Food habits:**
    a. Vegetarian
    b. Non-vegetarian
    c. Mixed
    d. Vegan
10. **Other habits:**
    a. Hot beverages(tea/coffee)
    b. Smoking
    c. Alcohol
    d. Tobbaco
    e. None
11. **Pattern of sleep**
    a. Sound sleep
    b. Disturbed sleep
    c. Sleeplessness

d. Excess sleep/day sleep

12. Do you workout/excercise regularly

a. Yes,daily

b. 1-3 days/week

c. More than 3days

d. No/rarely

13. Are you able to appreciate the different tastes of food regularly?*

Always (0)

Frequently (1)

Occasionally (2)

Never (3)

14. Which taste particularly you crave for?(you can select multiple options)*

Sweet

Salt

Sour

Spicy

Bitter

Pungent

No cravings

15. What is the time required for the digestion of your food?(digestion of food includes: getting clear belches, lightness in stomach, feeling hungry)*

3hrs (0)

3-6hrs (1)

>6hrs (2)

16. Which of the following is true in the stomach after having food?

Feel comfortable

Feel discomfort

17. Do you get reflux (getting taste of food(burp) hours after eating), if yes how often? (you can select multiple options)*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

18. What is the type of belch?

Sweet

Sour

Putrid smell(bad)

19. How frequent you feel thirsty even after having sufficient amount of water?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

20. How often you feel stickiness/sweetness(coating) in mouth?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

21. How often you feel tired physically?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

22. How often you feel stressed mentally?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

23. Do you feel lethargic(lazy)to start /do any work?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

24. How often you feel pain in the flanks, neck, thigh, or cardiac region?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

25. Do you often suffer from cold or cough?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

26. Do you feel nausea(vomiting sensation)?*

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

27. Do you experience any abnormal sound in ears?*

Whistle sound

Ringing sound

Whoosing sound(wind)

Other abnormal sound, specify:_____

Nothing specific

28. How often you experience blurring of vision?

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

29. Have you observed the weight loss without any obvious reason? if yes, since when

Since 3 months

>3months to <6months

>6months to less than a year

More than a year

No weight loss observed

30. When do you feel gas formation in the abdomen? (you can select multiple options)

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

31. If Yes, When do you experience the gas formation in the abdomen? (you can select multiple options)

Soon after having food

During the digestion

After digestion

Not applicable

32. Do you experience indigestion of food? If yes, is it associated with (you can select multiple options)

Bloating of abdomen

Constipation

Gurgling sound of the intestines

Pain

Stiffness in the body

Giddiness

Burning Sensation

Thirsty

Fainting

Sour belch

Sweating

Heaviness in the body

Excessive Salivation

Regurgitation immediately after having food

Swelling around the eyes

Diminution of digestive fire

Not Applicable

33. How frequently you pass motions/stools?

Once/day

Twice/day

Once in 2days

Once in 3days or more days

Specify other:

34. What is the consistency of stool (motions) formed? (you can select multiple options)*

Well formed

Liquidy/watery

Improperly formed

Diarrhoea with thick mucus

Heavy/bulky

Associated with bleeding

35. How is the nature of the stools(motion) formed? (you can select multiple options)

Soft/normal

Dry

Yellowish

Bluish

Putrid smell

36. Can you see undigested food in stool(motion)?

Yes

No

37. Do you feel itching in the anal region (where you pass motion)?

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

38. Do you have a feel of having/suffering from any disease?

Never (0)

Occasionally (1)

Frequently (2)

Always (3)

39. Are you diagnosed from any of the following disease?

Depression

Thyroid disorder

Diabetes

Cardiovascular disease

Tuberculosis

Irritable bowel syndrome

Ulcerative colitis

Any other specify_____

Nothing specific

Remarks:

Conclusion:

Your feedback is really important to us and we really appreciate the time you have taken to participate in this research project. Your contribution will help people for assessment and also the practitioner for diagnosis and to identify its cause and to improve the quality of the food and lifestyle. We will share the results with you and would like to invite you to participate in our next survey if it passes the criteria. Once again, many thanks for sharing your thoughts, views and opinions.