

APPENDIX - I

PHASE: I - QUESTIONNAIRE

SOCIO DEMOGRAPHIC STATUS

- 1) Name:
- 2) Address:
- 3) Age (years):
- 4) Marital Status: ☐ Married
☐ Unmarried
☐ Divorced
☐ Widow / Widower
- 5) Religion: Hindu / Non Hindu
- 6) Ethnic group: Gujarati / Non Gujarati: specify
- 8) Education: ☐ Primary school
☐ Metric pass (10th)
☐ High school (12th)
☐ University: graduate/post graduate
☐ Illiterate
- 9) Living arrangement: ☐ Living alone
☐ Living with spouse
☐ Living with children
- 10) Family composition:

Sr. No.	Age	Sex	Relation	Income
1.				
2.				
3.				
4.				
5.				

11) Total income of the family: _____

12) Per capita income: _____

- 13) Source of income: () Dependent
() Self sufficient: Fully/Partial/pensioner

ACTIVITY PATTERN:

() Sedentary () Moderate

Time spent for various activities like

- (a) Routine _____
- (b) Recreational _____
- (c) Religious _____
- (d) Social _____
- (e) Leisure _____
- (f) Exercise _____

FOOD ACTIVITY RELATED PROBLEMS

1. PURCHASING

(B) FOOD ACTIVITY RELATED PROBLEMS
(I) PURCHASING

Sr. No.	Food item	Purchased by				Frequency of purchase				Distance from house to shop			Mode of transport		If you do not purchase does it limit your choice	
		Self	Spouse	children	Servant	Daily	2-3 times a week	Monthly	Yearly	<1/2 km	>1/2 km	>1 km	Walking private, Public	Yes	No	
1	Grocery															
2	Fruits and Vegetable															
3	Milk															
4	Sweets & Farshan															
5	Convenient foods															

(II) Do you face any kind of problem while purchasing? ()

Cannot see properly in dim light ()

Counting money ()

Carrying bag ()

Longer distance ()

Vehicle problem ()

Lack of storage space ()

Market is crowded ()

Roads are irregular / difficulty in crossing roads ()

Fatigue ()

2. STORONG

➤ Source of help for storing and cleaning of food grains

Self only ()
Spouse ()
Servant ()
Children ()
Others ()

➤ Do you find difficulty in

(a) Storing foods

Improper facilities ()
Lack of space ()
Disability ()
Rodents/ insects ()

(b) Handling stored foods

Unable to reach/ inconviement ()
Cannot see properly ()
Opening ()
Climbing ()
Cannot carry weight ()
Sitting down and getting up ()
Any other

3. PREPREPARATION OF FOODS

➤ Source of help

Self only ()
Spouse ()
Servant ()
Children ()
Others ()

➤ What type of electrical appliances do you have?

Food processor/ mixer ()
Oven OTG/ microwave ()
Cooking range ()
Flourmill () any other, specify _____

➤ Do you find difficulty in operating electrical appliances

Fear ()
Do not know how to use ()
Lack of confidence ()
Cannot read and reach ()
Shivering hands ()
Difficulty in handling heavy items ()
Difficulty in gripping them ()

4. COOKING

➤ Source of help

- Self only ()
 Assistance in cooking ()
 Children ()
 Co-hired help (cook) ()

➤ If cook is employed then any problems

- Do not listen ()
 Comes late ()
 Irregular ()
 Unhygienic habits ()

➤ If self cooking than any difficulty

- Standing platform is inconvenient ()
 Unable to see small things ()
 Cannot cope up with timings ()
 Distance between store and kitchen is long ()
 Likes and dislikes of family members ()
 Pain in shoulders/ back pain ()

➤ Do you plan your menu? Yes / No

If yes, do you simplify it and how frequently

	Daily	2-3 times / week	Occasionally
Preparing simple foods			
Avoid elaborate preparations			
Prepare for two meals			
Do not prepare full meal			
Get from outside			

If no, whether your choice is considered Yes / No

➤ Are you satisfied with cooking practices followed at your home? Yes/ No

If no, why?

- Taste is not proper ()
 Consistency improper ()
 Dislike food itself ()
 Any other, specify _____

➤ Water storage facility and difficulty

- Lack of space ()
 Far from cooking area ()
 Any other, specify _____

5. EATING / SERVING

➤ Source of help

Self only ()
Spouse ()
Servant ()
Children ()
Others ()

➤ Do you need assistance in eating? Yes / No

➤ Do you have problems in eating and serving?

Cleaning dinning area ()
Ling distance between kitchen & dinning ()
Feeling lonely ()
Disturbance while eating ()
Improper timings ()
Improper sitting arrangements ()

➤ Normal water intake

Less than 6 glasses / day ()
6 – 8 glasses / day ()
More than 8 glasses / day ()

➤ Reasons for avoiding drinking water

Far away ()
Nocturia ()
Do not feel thirsty ()
Feel lazy ()
Need desired temperature ()
Any other, specify _____

6. GENERAL

➤ Are you satisfied with the meals you eat with respect to choice and preparation of foods? Yes / No

If No, specify reasons

Lonely ()

Any other, specify _____

➤ If given a choice would you like to help to take help / assistance for purchasing to serving of food activities? Yes / No

If No, why, specify reasons,

Financial constraints ()

Do not like outside interference ()

Do not like servants ()
Any other, specify _____

➤ If readymade wholesome food of your choice is given to you would you prefer that? Yes / No

If yes, specify reasons

Saves time ()

Get balanced food ()

Convenient ()

Reduces problems for food ()

Any other _____

➤ Up to what cost limit you can prefer to buy such convenient meal?

Less than Rs.15/meal

Rs.15-30/ meal

More than Rs.30/ meal

HEALTH PROFILE

1. What is the status of your health according to you?

Excellent () Fair ()

All right for age () Poor ()

2. Sleep pattern

Sound () Disturbed () Unable to sleep ()

3. Sense organs

(a) Eyes: Normal () Cataract () One abnormal ()

Both abnormal () Weak/spectacles/use watch glass ()

(b) Hearing: Normal () One abnormal () Both abnormal ()

Use hearing aid ()

(c) Taste: Normal () Poor liking towards different taste ()

(d) Smell: Normal () Abnormal ()

(e) Walking: Normal () Needs stick support ()

Unable to walk ()

4. Do you have enough facilities for maintaining good health

Health foods ()

Medicines ()

Tonics/supplements ()

5. Who bares your medical expenses?

Self () Son () Daughter () Family funds ()

No expenses () Any other, specify _____

6. Do you have any medical conditions or problems? Yes / No

If yes, describe its impact on you _____

NUTRITIONAL STATUS

DIET RELATED INFORMATION

A. Are you: () vegetarian () non-vegetarian

B. 1. Meal pattern:

Meal Pattern	Regular	Irregular
Bed Tea		
Break Fast		
Mid Morning		
Brunch		
Lunch		
Evening Snacks		
Dinner		
Bed time		

2. Type of diet at present and reasons:

TYPE

Normal
Soft
Liquid
Salt restricted
Sugar restricted
Bland

REASONS

High Blood pressure
Diabetes
Heart Disease
Acidity
Precautionary
Teeth Problem

C. Food Preferred:

1. Your preferred food taste: () Sweet () Spicy () Salty () Sour () Bland

2. Do you have habit of munching foods: () Yes () No

D. Fasting pattern

No. of days/week/month

Reasons

Full fasting ()

Milk and fruits ()

Non-cereal foods ()

One meal a day ()

No fasting ()

Religious ()

Financial ()

Health ()

Dislike food ()

Loss of appetite ()

Difficulty in preparing ()

Any other specify ()

E. Food related problem

1. Chewing
2. Swallowing
3. Digestion: Flatulence/ acidity/ constipation/ diarrhoea

F. Eating practices

1. Do you eat with any company: alone/ spouse/family
2. Substitute for meal
 - a. Milk: Do you drink milk? () Yes () No
Frequency: Regular/ irregular/ during fasting/ never
 - b. Bread: Do you eat bread? () Yes () No

Frequency/ week	Replaced for meal	Reasons
Once ()	Breakfast ()	Convenient ()
2-3 times ()	Lunch ()	Easy to chew and digest ()
Daily ()	Snacks ()	Any other specify
	Dinner ()	

c. Farshan (frequency)

- On occasions ()
 As replacement of meal (Dinner) ()
 Along with meal ()
 Any other specify () _____

d. Ready food items:

Do you get tiffins (), food packets (), tins (), quick cooking foods ()
 If yes, give frequency:

Frequently () () () ()
 Once a week () () () ()
 Once a month () () () ()
 Occasionally () () () ()

e. Eating out:

Do you go to eat out () Yes () No
 If yes,

Meal	Frequently	Once a week	Once a month	Occasionally
Thali				
Fast food				
Meal of choice				

f. Meal adjustment:

How do you make adjustment with evening meal? Why?

Adjustments		Reasons	
Use left over foods	()	Digestion problem	()
Leftover with addition	()	Difficulty in preparing	()

Prepare snacks/easy item () Poor eye sight in evening ()
 Partial fasting/milk & fruit () Fatigue ()
 Khakhara / roti () No help ()

g. Food intake

(i) Food frequency

(a) Uncooked foods

Uncooked foods	Daily	2-3 times / week	Once a week	Once a month	Occasionally
Fruits					
Milk products					
Nuts & oilseeds					
Salads					

(b) Cooked foods

Raw foods	Daily	2-3 times / week	Once a week	Once a month	Occasionally
Cumbersome vegetables					
Snacks					
Sweets					
Baked items					
Fermented food items					
Other varieties					
Beverages					
Seasonal health foods					
Summer					
Winter					
Monsoon					

24 HOUR DIETARY RECALL

Meal	Food items	Ingredients	Cooked (ml)	Raw (gm)

Nutrient Calculation

Ingredient	Raw amount	Energy (kcal)	Protein (gm)	Fat (gm)	Calcium (mg)	Iron (mg)	β -carotene (μ g)	Vit.C (mg)
Total								

RDA								
Deficit								

Tools (1) Measuring cups, spoons and glass (2) Cooked to raw conversion table.

ANTROPOMETRIC MEASUREMENTS

Weight in kgs: _____ MUAC: _____ cm
Height in cms: _____ BMI: _____ kg/m²

CLINICAL INFORMATION

Haemoglobin level: _____ gm/dl

Random blood sugar: _____ mg/dl

Blood pressure: _____ mmHg (systolic/diastolic)

DISEASE PROFILE: CHECK LIST

I. MAJOR ILLNESS

YES / NO

1. Duodenal ulcer
2. Liver disease
3. Diabetes Mellitus
4. Tuberculosis
5. Asthma / Respiratory problem
6. Ischemic heart disease
7. Hyperlipedemia
8. Hypertension
9. Rheumatoid arthritis / osteoarthritis
10. Gynec / Obstetric problem
11. Convulsive attack
12. Any disability

II. MINOR ILLNESS

YES / NO

1. Dental problems
2. Burning in chest (heart burn)
3. Fullness/ gaseous distension
4. Flatulence
5. Abdominal pain
6. Diarrhoea
7. Dysentery
8. Constipation
9. Recurrent cold

10. Irritating cough
11. Pain in swallowing
12. Pneumonia
13. Urinary tract infection
14. Pain in lower abdomen
15. Chest pain
16. Nausea
17. Vomiting
18. Headache
19. Body ache
20. Sleep disturbances
21. Urinary incontinence
22. Slow reflexes (slow daily routine activity)
23. General weakness
24. Soreness / dryness of mouth
25. Dryness of skin
26. Trembling of limbs
27. Mood swings
28. Pain in joints