

No#

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:

Past 30 DAYS

Past few MONTHS

<b>Point Scale</b>	<b>0</b> Never or almost never have the symptom	<b>3</b> Frequently have it, effect is not severe
	<b>1</b> Occasionally have it, effect is not severe	<b>4</b> Frequently have it, effect is severe
	<b>2</b> Occasionally have it, effect is severe	
	<i>Circle the words that are most accurately describe your symptoms</i>	

**HEAD**

\_\_\_\_\_ Headaches

\_\_\_\_\_ Faintness

\_\_\_\_\_ Dizziness

\_\_\_\_\_ Insomnia

\_\_\_\_\_ **TOTAL**

**EYES**

\_\_\_\_\_ Watery or itchy eyes

\_\_\_\_\_ Swollen, reddened or sticky eyelids

\_\_\_\_\_ Bags or dark circles under eyes

\_\_\_\_\_ Blurred or tunnel vision  
*(does not include near- or far-sightedness)*

\_\_\_\_\_ **TOTAL**

**EARS**

\_\_\_\_\_ Itchy ears

\_\_\_\_\_ Earaches, ear infections

\_\_\_\_\_ Drainage from ear

\_\_\_\_\_ Ringing in ears, hearing loss

\_\_\_\_\_ **TOTAL**

**NOSE / SINUS**

\_\_\_\_\_ Stuffy nose

\_\_\_\_\_ Sinus problems

\_\_\_\_\_ Hay fever

\_\_\_\_\_ Sneezing attacks

\_\_\_\_\_ Excessive mucus formation

\_\_\_\_\_ **TOTAL**

**MOUTH/ THROAT**

\_\_\_\_\_ Chronic coughing

\_\_\_\_\_ Gagging, frequent need to clear throat

\_\_\_\_\_ Sore throat, hoarseness, loss of voice

\_\_\_\_\_ Swollen or discoloured tongue, gums or lips

\_\_\_\_\_ Canker sores

\_\_\_\_\_ **TOTAL**

**SKIN**

\_\_\_\_\_ Acne

\_\_\_\_\_ Hives, rashes, dry skin

\_\_\_\_\_ Hair loss

\_\_\_\_\_ Flushing, hot flashes

\_\_\_\_\_ Excessive sweating

\_\_\_\_\_ **TOTAL**

**HEART**

\_\_\_\_\_ Irregular or skipped heartbeat

\_\_\_\_\_ Rapid or pounding heartbeat

\_\_\_\_\_ Chest pain

\_\_\_\_\_ **TOTAL**

**LUNGS**

\_\_\_\_\_ Chest congestion

\_\_\_\_\_ Asthma, bronchitis

\_\_\_\_\_ Shortness of breath

\_\_\_\_\_ Difficulty breathing

\_\_\_\_\_ **TOTAL**

**DIGESTIVE TRACT**

\_\_\_\_\_ Nausea, vomiting

\_\_\_\_\_ Diarrhea

\_\_\_\_\_ Constipation

\_\_\_\_\_ Bloating feeling

\_\_\_\_\_ Belching, passing gas

\_\_\_\_\_ Heartburn

\_\_\_\_\_ Intestinal/stomach pain

\_\_\_\_\_ **TOTAL**

**JOINTS / MUSCLE**

\_\_\_\_\_ Pain or aches in joints

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Stiffness or limitation of movement

\_\_\_\_\_ Pain or aches in muscles

\_\_\_\_\_ Feeling of weakness or tiredness

\_\_\_\_\_ **TOTAL**

**WEIGHT**

\_\_\_\_\_ Binge eating/drinking

\_\_\_\_\_ Craving certain foods

\_\_\_\_\_ Excessive weight

\_\_\_\_\_ Compulsive eating

\_\_\_\_\_ Water retention

\_\_\_\_\_ Underweight

\_\_\_\_\_ **TOTAL**

**ENERGY / ACTIVITY**

\_\_\_\_\_ Fatigue, sluggishness

\_\_\_\_\_ Apathy, lethargy

\_\_\_\_\_ Hyperactivity

\_\_\_\_\_ Restlessness

\_\_\_\_\_ **TOTAL**

**MIND**

\_\_\_\_\_ Poor memory

\_\_\_\_\_ Confusion, poor comprehension

\_\_\_\_\_ Poor concentration

\_\_\_\_\_ Poor physical coordination

\_\_\_\_\_ Difficulty in making decisions

\_\_\_\_\_ Stuttering or stammering

\_\_\_\_\_ Slurred speech

\_\_\_\_\_ Learning disabilities

\_\_\_\_\_ **TOTAL**

**EMOTIONS**

\_\_\_\_\_ Mood swings

\_\_\_\_\_ Anxiety, fear, nervousness

\_\_\_\_\_ Anger, irritability, aggressiveness

\_\_\_\_\_ Depression

\_\_\_\_\_ **TOTAL**

**OTHER**

\_\_\_\_\_ Frequent illness

\_\_\_\_\_ Frequent or urgent urination

\_\_\_\_\_ Genital itch or discharge

\_\_\_\_\_ **TOTAL**

**GRAND TOTAL** \_\_\_\_\_

