

# DEBORA CHELSON, N.M.D.

11650 E. Old Spanish Trail, Tucson, AZ 85730 ♦ (520) 437-9562

## Patient Symptoms Checklist

*Rate each of the following symptoms based upon your health profile for the past 90 days.  
Please be sure to enter a point value, and not just a check mark!*

### POINT SCALE

**0 = Never or almost never have the symptom**

**1 = Occasionally have it, effect is not severe**

**2 = Occasionally have it, effect is severe**

**3 = Frequently have it, effect is not severe**

**4 = Frequently have it, effect is severe**

#### DIGESTIVE TRACT

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching, or passing gas
- Heartburn

TOTAL \_\_\_\_\_

#### EARS

- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

TOTAL \_\_\_\_\_

#### EMOTIONS

- Mood swings
- Anxiety, fear or nervousness
- Anger, irritability, or aggressiveness
- Depression

TOTAL \_\_\_\_\_

#### ENERGY / ACTIVITY

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

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 \_\_\_\_\_

#### HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

TOTAL \_\_\_\_\_

#### HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

TOTAL \_\_\_\_\_

|                             |                          |  |             |
|-----------------------------|--------------------------|--|-------------|
| <b>JOINTS /<br/>MUSCLES</b> | <input type="checkbox"/> | Pain or aches in joints                  |             |
|                             | <input type="checkbox"/> | Arthritis                                |             |
|                             | <input type="checkbox"/> | Stiffness or limitation of movement      |             |
|                             | <input type="checkbox"/> | Pain or aches in muscles                 |             |
|                             | <input type="checkbox"/> | Feeling of weakness or tiredness         | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>LUNGS</b>                | <input type="checkbox"/> | Chest congestion                         |             |
|                             | <input type="checkbox"/> | Asthma, bronchitis                       |             |
|                             | <input type="checkbox"/> | Shortness of breath                      |             |
|                             | <input type="checkbox"/> | Difficulty breathing                     | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>MIND</b>                 | <input type="checkbox"/> | Poor memory                              |             |
|                             | <input type="checkbox"/> | Confusion, poor comprehension            |             |
|                             | <input type="checkbox"/> | Poor concentration                       |             |
|                             | <input type="checkbox"/> | Poor physical coordination               |             |
|                             | <input type="checkbox"/> | Difficulty in making decisions           |             |
|                             | <input type="checkbox"/> | Stuttering or stammering                 |             |
|                             | <input type="checkbox"/> | Slurred speech                           |             |
|                             | <input type="checkbox"/> | Learning disabilities                    | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>MOUTH /<br/>THROAT</b>   | <input type="checkbox"/> | Chronic coughing                         |             |
|                             | <input type="checkbox"/> | Gagging, frequent need to clear throat   |             |
|                             | <input type="checkbox"/> | Sore throat, hoarseness, loss of voice   |             |
|                             | <input type="checkbox"/> | Swollen or discolored tongue, gums, lips |             |
|                             | <input type="checkbox"/> | Canker sores                             | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>NOSE</b>                 | <input type="checkbox"/> | Stuffy nose                              |             |
|                             | <input type="checkbox"/> | Sinus problems                           |             |
|                             | <input type="checkbox"/> | Hay fever                                |             |
|                             | <input type="checkbox"/> | Sneezing attacks                         |             |
|                             | <input type="checkbox"/> | Excessive mucus formation                | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>SKIN</b>                 | <input type="checkbox"/> | Acne                                     |             |
|                             | <input type="checkbox"/> | Hives, rashes, or dry skin               |             |
|                             | <input type="checkbox"/> | Hair loss                                |             |
|                             | <input type="checkbox"/> | Flushing or hot flashes                  |             |
|                             | <input type="checkbox"/> | Excessive sweating                       | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>WEIGHT</b>               | <input type="checkbox"/> | Binge eating/drinking                    |             |
|                             | <input type="checkbox"/> | Craving certain foods                    |             |
|                             | <input type="checkbox"/> | Excessive weight                         |             |
|                             | <input type="checkbox"/> | Compulsive eating                        |             |
|                             | <input type="checkbox"/> | Water retention                          |             |
|                             | <input type="checkbox"/> | Underweight                              | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>OTHER</b>                | <input type="checkbox"/> | Frequent illness                         |             |
|                             | <input type="checkbox"/> | Frequent or urgent urination             |             |
|                             | <input type="checkbox"/> | Genital itch or discharge                | TOTAL _____ |
| <hr/>                       |                          |  |             |
| <b>GRAND TOTAL</b>          |                          |  | _____       |