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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 <u>point value</u>, 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	
	_____ Bloated 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 _____

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

GRAND TOTAL _____