Symptom Survey

Date:	Patient Name:	Patient Signature:

Please fill in the following form completely. Score every symptom based on your experience over the last 30 days. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed.

If You Don't Suffer From This Ever or Almost Ever **LEAVE IT BLANK**.
●○○○ = 1 = Suffered OCCASSIONALLY (less than 2 times per week), symptom **wasn't severe**
○●○○ = 2 = Suffered FREQUENTLY (2 or more times per week), symptom **wasn't severe**
○○●○ = 3 = Suffered OCCASSIONALLY and symptom **was severe**
○○○● **= 4 =** Suffered FREQUENTLY and symptom **was severe**

CONSTITUTIONAL
○○○○ Fatigue (sluggish, tired)
○○○○ Hyperactive (nervous energy)
○○○○ Restless (can't relax/sit still)
○○○○ Sleepiness During Day
○○○○ Insomnia at Night
○○○○ Malaise (Feel Lousy)
______ TOTAL (0-24)

EMOTIONAL/MENTAL
○○○○ Depression
○○○○ Anxiety
○○○○ Mood Swings
○○○○ Irritability
○○○○ Forgetfulness
○○○○ Lack of concentration/focus
______ TOTAL (0-24)

HEAD/EARS
○○○○ Migraine (diagnosed)
○○○○ Headache (any kind)
○○○○ Earache
○○○○ Ear Infection
○○○○ Ringing in Ear
○○○○ Itchy Ears
○○○○ Discharge From Ears
_____ TOTAL (0-28)

SKIN
○○○○ Blemishes, Acne
○○○○ Rashes, Hives
○○○○ Eczema
○○○○ "Rosy" Cheeks
______ TOTAL (0-16)

NASAL/SINUS
○○○○ Post Nasal Drip
○○○○ Sinus Pain
○○○○ Runny Nose
○○○○ Stuffy Nose
○○○○ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT
○○○○ Sore Throat
○○○○ Swollen Throat
○○○○ Swelling of Lips/Tongue
○○○○ Gagging/Throat Clearing
○○○○ Canker Sores
_____ TOTAL (0-20)

LUNGS
○○○○ Wheezing
○○○○ Chest Congestion
○○○○ Dry Cough
○○○○ Wet Cough
_____ TOTAL (0-16)

EYES
○○○○ Red or Swollen Eyes
○○○○ Watery Eyes
○○○○ Itchy Eyes
○○○○ Dark Circles" or "Bags"
_____ TOTAL (0-16)

GENITOURINARY
○○○○ Increased Urinary Frequency
○○○○ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL
○○○○ Joint Pains/Aching
○○○○ Stiff Joints
○○○○ Muscle Aches
○○○○ Stiff Muscles
_____ TOTAL (0-16)

CARDIOVASCULAR
○○○○ Irregular Heartbeat
○○○○ High Blood Pressure
_____ TOTAL (0-8)

DIGESTIVE
○○○○ Heartburn/Reflux
○○○○ Stomach Pains/Cramps
○○○○ Intestinal Pains/Cramps
○○○○ Constipation
○○○○ Diarrhea
○○○○ Bloating Sensation
○○○○ Gas (of Any Kind)
○○○○ Nausea, Vomiting
○○○○ Painful Elimination
______ TOTAL (0-36)

WEIGHT MANAGEMENT
______ **Record Actual Weight**
○○○○ Fluctuating Weight
○○○○ Food Cravings
○○○○ Water Retention
○○○○ Binge Eating or Drinking
○○○○ Purging (all methods)
_____ TOTAL (0-20)

GRAND TOTAL

Are there any foods you would be unable or unwilling to give up for two weeks in order to get better?