

Symptom Survey

Date:	Patient Name:	Patient Signature:
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In order to provide our patients with the best possible health care, please fill in the following form completely. Score every symptom based on your experience over the last 30 days, or since your last Symptom Survey, whichever was most recent. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS:

- = 0 = Did Not Suffer From This Ever or Almost Ever
- = 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**

Grand Total:

<p>CONSTITUTIONAL</p> <p>○○○○○ Fatigue (sluggish, tired)</p> <p>○○○○○ Hyperactive (nervous energy)</p> <p>○○○○○ Restless (can't relax/sit still)</p> <p>○○○○○ Sleepiness During Day</p> <p>○○○○○ Insomnia at Night</p> <p>○○○○○ Malaise (Feeling Lousy)</p> <p>_____ TOTAL (0-24)</p> <p>EMOTIONAL/MENTAL</p> <p>○○○○○ Depression</p> <p>○○○○○ Anxiety</p> <p>○○○○○ Mood Swings</p> <p>○○○○○ Irritability</p> <p>○○○○○ Forgetfulness</p> <p>○○○○○ Lack of concentration/focus</p> <p>_____ TOTAL (0-24)</p> <p>HEAD/EARS</p> <p>○○○○○ Migraine (any kind)</p> <p>○○○○○ Headache (other than Migraine)</p> <p>○○○○○ Earache</p> <p>○○○○○ Ear Infection</p> <p>○○○○○ Ringing in Ear</p> <p>○○○○○ Itchy Ears</p> <p>○○○○○ Discharge From Ears</p> <p>_____ TOTAL (0-28)</p> <p>SKIN</p> <p>○○○○○ Blemishes, Acne</p> <p>○○○○○ Rashes, Hives</p> <p>○○○○○ Eczema</p> <p>○○○○○ "Rosy" Cheeks</p> <p>_____ TOTAL (0-16)</p>	<p>NASAL/SINUS</p> <p>○○○○○ Post Nasal Drip</p> <p>○○○○○ Sinus Pain</p> <p>○○○○○ Runny Nose</p> <p>○○○○○ Stuffy Nose</p> <p>○○○○○ Sneezing</p> <p>_____ TOTAL (0-20)</p> <p>MOUTH/THROAT</p> <p>○○○○○ Sore Throat</p> <p>○○○○○ Swollen Throat</p> <p>○○○○○ Swelling of Lips/Tongue</p> <p>○○○○○ Gagging/Throat Clearing</p> <p>○○○○○ Canker Sores</p> <p>_____ TOTAL (0-20)</p> <p>LUNGS</p> <p>○○○○○ Wheezing</p> <p>○○○○○ Chest Congestion</p> <p>○○○○○ Dry Cough</p> <p>○○○○○ Wet Cough</p> <p>_____ TOTAL (0-16)</p> <p>EYES</p> <p>○○○○○ Red or Swollen Eyes</p> <p>○○○○○ Watery Eyes</p> <p>○○○○○ Itchy Eyes</p> <p>○○○○○ Dark Circles" or "Bags"</p> <p>_____ TOTAL (0-16)</p> <p>GENITOURINARY</p> <p>○○○○○ Increased Urinary Frequency</p> <p>○○○○○ Painful Urination</p> <p>_____ TOTAL (0-8)</p>	<p>MUSCULOSKELETAL</p> <p>○○○○○ Joint Pains/Aching</p> <p>○○○○○ Stiff Joints</p> <p>○○○○○ Muscle Aches</p> <p>○○○○○ Stiff Muscles</p> <p>_____ TOTAL (0-16)</p> <p>CARDIOVASCULAR</p> <p>○○○○○ Irregular Heartbeat</p> <p>○○○○○ High Blood Pressure</p> <p>_____ TOTAL (0-8)</p> <p>DIGESTIVE</p> <p>○○○○○ Heartburn/Reflux</p> <p>○○○○○ Stomach Pains/Cramps</p> <p>○○○○○ Intestinal Pains/Cramps</p> <p>○○○○○ Constipation</p> <p>○○○○○ Diarrhea</p> <p>○○○○○ Bloating Sensation</p> <p>○○○○○ Gas (of Any Kind)</p> <p>○○○○○ Nausea, Vomiting</p> <p>○○○○○ Painful Elimination</p> <p>_____ TOTAL (0-36)</p> <p>WEIGHT MANAGEMENT</p> <p>_____ Record Actual Weight</p> <p>○○○○○ Fluctuating Weight</p> <p>○○○○○ Food Cravings</p> <p>○○○○○ Water Retention</p> <p>○○○○○ Binge Eating or Drinking</p> <p>○○○○○ Purging (all methods)</p> <p>_____ TOTAL (0-20)</p>
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