

# 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.

### SCALE OF SYMPTOM POINTS:

If You Don't Suffer From This Ever or Almost Ever **LEAVE IT BLANK.**

●○○○ = 1 = Suffered OCCASIONALLY (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 OCCASIONALLY 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)