Medical Symptoms Questionnaire

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

Rate each of the following symptoms based upon your typical health profile for the past 30 days OR since your last visit.

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Water or itchy eyes
_____ Swollen, reddened, or sticky eyelids
_____ Bags/Dark circles under eyes
_____ Blurred/Tunnel vision
_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay Fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

HEART
_____ Irregular/Skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest Pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS/MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Stuttering or Stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

ENERGY/ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent, urgent, difficult, or painful urination
_____ Genital itch or discharge
_____ TOTAL

Y Are you moving your body?
N

GRAND TOTAL:_____

STRESS: Are you stressed in any of these areas? Please circle (physical, emotional, intellectual or spiritual)

What **supplement/medications** do you take? How often and what dose?_____

NB: On a scale of 1-10 (10 means optimal), where do you ***self rate your overall health*** for the past 30 days? _____/10

REASON FOR TODAY'S APPOINTMENT:_____

NAME:_____ AGE:_____ DATE:_____