

NAME _____

DATE _____

WEEK _____

Rate each of the following symptoms based upon your typical health profile for: Past 30 days Past 48 hours

Point Scale	0	Never or almost never have the symptom	3	Frequently have it, effect is <i>not</i> severe
	1	Occasionally have it, effect is <i>not</i> severe	4	Frequently have it, effect is severe
	2	Occasionally have it, effect is severe		

HEAD

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

_____ TOTAL

DIGESTIVE TRACT

_____ Nausea, vomiting

_____ Diarrhea

_____ Constipation

_____ Bloating feeling

_____ Belching, passing gas

_____ Heartburn

_____ Intestinal/stomach pain

_____ 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

JOINTS / MUSCLE

_____ Pain or aches in joints

_____ Arthritis

_____ Stiffness or limitation of movement

_____ Pain or aches in muscles

_____ Feeling of weakness or tiredness

_____ TOTAL

EARS

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

_____ TOTAL

WEIGHT

_____ Binge eating/drinking

_____ Craving certain foods

_____ Excessive weight

_____ Compulsive eating

_____ Water retention

_____ Underweight

_____ TOTAL

NOSE

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

_____ TOTAL

ENERGY / ACTIVITY

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness

_____ TOTAL

MOUTH / THROAT

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen or discolored tongue, gums or lips

_____ Canker sores

_____ TOTAL

MIND

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ TOTAL

SKIN

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

_____ TOTAL

HEART Irregular or skipped heartbeat
 Rapid or pounding heartbeat
 Chest pain
 TOTAL

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

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

OTHER Frequent illness
 Frequent or urgent urination
 Genital itch or discharge
 TOTAL

GRAND TOTAL