— HEALTH SURVEY

Initial Symptom *Survey.*

Rate each symptom based on your experience DURING THE PAST MONTH. Using the Symptom Point Scale below, WRITE the corresponding score to the LEFT of EACH listed symptom. Write the "Overall Total" at the top. Also note the number of workdays missed in the past month due to illness.

Date Patient Name Practitioner

SYMPTOM POINT SCALE

If you NEVER had the symptom, or almost never, leave blank.

1 = OCCASIONALLY (less than 2×/week) and symptom was MILD

2 = FREQUENTLY (2+ ×/week) and symptom was MILD

3 = OCCASIONALLY (less than 2×/week) and symptom was SEVERE

4 = FREQUENTLY (2+ ×/week) and symptom was SEVERE

Overall Total _____ Workdays Lost _____

GENERAL (CONSTITUTIONAL) *Total (0-28)*

___ Fatigue (sluggishness, tiredness)
___ Hyperactivity (nervous energy)
___ Restlessness (cannot relax/sit still)
___ Sleepiness during the day
___ Insomnia at night
___ General malaise (feeling unwell)
___ Convulsions

EMOTIONAL / MENTAL *Total (0-28)*

___ Depression
___ Anxiety (fears, worry)
___ Mood swings (rapid changes)
___ Irritability

___ Forgetfulness
___ Poor concentration / brain fog
___ Low sex drive

HEAD / EARS *Total (0-32)*

___ Headache (non-migraine)
___ Migraine
___ Earache
___ Ear infection
___ Ringing in ears
___ Itching in ears
___ Ear discharge
___ Sensitivity to sound

SKIN *Total (0-24)*

___ Blemishes, acne
___ Rash or hives
___ Eczema or psoriasis
___ Flushed cheeks
___ Sudden flushing
___ Itchy skin

NOSE / SINUSES *Total (0-20)*

___ Postnasal drip
___ Sinus pain
___ Runny nose
___ Nasal congestion
___ Sneezing

MOUTH / THROAT *Total (0-24)*

___ Sore throat
___ Swollen throat
___ Lip/tongue swelling or burning
___ Gagging / throat clearing
___ Canker sores

___ Difficulty swallowing

LUNGS *Total (0-20)*

___ Wheezing
___ Chest congestion
___ Dry cough
___ Productive cough
___ Shortness of breath

EYES *Total (0-24)*

___ Red or swollen eyes
___ Watery eyes
___ Itchy eyes
___ Dark circles or bags
___ Light sensitivity
___ Aura

GENITOURINARY *Total (0-16)*

___ Increased urinary frequency
___ Painful urination
___ Bladder pain
___ Bedwetting

MUSCULOSKELETAL *Total (0-28)*

___ Joint pain
___ Joint stiffness
___ Muscle aches
___ Muscle stiffness
___ Tics (facial or other)
___ Muscle spasms
___ Muscle cramps

CARDIOVASCULAR *Total (0-8)*

___ Irregular heartbeat
___ High blood pressure

DIGESTIVE *Total (0-40)*

___ Heartburn / reflux
___ Stomach pain / cramps
___ Intestinal pain / cramps
___ Constipation
___ Diarrhea
___ Bloating sensation
___ Gas (any kind)
___ Nausea
___ Vomiting
___ Painful bowel movement

WEIGHT / CONTROL *Total (0-20)*

___ Fluctuating weight
___ Food cravings
___ Fluid retention
___ Binge eating or drinking
___ Purging (any method)

Current weight: _____ lbs

Note any other symptoms: