

Name _____ Date _____

Rate each of the following symptoms based on how you've been feeling for the: Past 48 hours Past Week Past 30 days

Point Scale

0 — Never or almost never have the symptoms	2 — Occasionally have it, effect is severe
1 — Occasionally have it, effect is not severe	3 — Frequently have it, effect is not severe
	4 — Frequently have it, effect is severe

Head

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

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 farsightedness)

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 or discolored tongue, gums or lips

_____ Canker sores

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 _____

Lungs

_____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing

Total _____

Digestive Tract

_____ Nausea, vomiting

_____ Diarrhea

_____ Constipation

_____ Bloating feeling

_____ Belching, passing gas

_____ Heartburn

_____ Intestinal/stomach pain

Total _____

Joints/Muscles

_____ 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 _____

Energy/Activity

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness

Total _____

Mind

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

Total _____

Emotions

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression

Total _____

Other

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

Total _____

Grand Total _____