

# Symptom Survey

Date:		Name:		Dietitian:	
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Please rate the **intensity** and **frequency** of your symptoms using the **scale of symptom points** listed below. Score **every** symptom based on your **average experience weekly over the last month**.

- BLANK = NEVER or RARELY** have this symptom  
**1 = Was MILD and OCCASIONAL** (1 time per week or less)  
**2 = Was MILD and FREQUENT** (2 or more times per week)  
**3 = Was SEVERE and OCCASIONAL** (1 time per week or less)  
**4 = Was SEVERE and FREQUENT** (2 or more times per week)

Grand Total Symptom Points:	
Number of Missed Work or School Days in Past Month:	

ENERGY/WELLNESS	NASAL/SINUS	MUSCULOSKELETAL
Fatigue (sluggish, tired)	Post nasal drip	Stiff or painful joints
Low Energy, Tire quickly	Sinus pain	Stiff or achy muscles
Restless (can't relax/sit still)	Runny nose	Muscle spasms or cramps
Daytime sleepiness	Stuffy nose	<b>TOTAL (0-12)</b>
Insomnia at night	Sneezing	CARDIOVASCULAR
Malaise (feeling lousy)	<b>TOTAL (0-20)</b>	Irregular heartbeat
<b>TOTAL (0-24)</b>	MOUTH/THROAT	Rapid heartbeat (tachycardia)
EMOTIONAL/MENTAL	Dry mouth	High blood pressure
Depression	Sore/Swollen throat or tongue	Cold hands/feet
Anxiety (fears, uneasiness)	Swelling/burning lips/tongue	<b>TOTAL (0-16)</b>
Mood swings (rapid changes)	Gagging/throat clearing	DIGESTIVE
Irritability	Canker sores, mouth sores	Heartburn/reflux
Forgetfulness/Poor Memory	Difficulty swallowing	Spasms of the esophagus
Poor concentration/brain fog	<b>TOTAL (0-24)</b>	Stomach pains/cramps
Low sex drive	LUNGS	Intestinal pains/cramps
<b>TOTAL (0-28)</b>	Wheezing	Constipation
NEUROLOGICAL	Chest congestion	Diarrhea
Headache (not migraine)	Chronic cough, wet or dry	Painful elimination
Migraine/Aura (visual, other)	Shortness of breath	Bloating sensation
Dizziness or vertigo	<b>TOTAL (0-16)</b>	Gas (of any kind)
Hyperactive (nervous energy)	EYES	Nausea
Confusion	Red or swollen eyes	Vomiting
Tics/twitches, or seizures	Watery eyes	<b>TOTAL (0-44)</b>
Tingling/Numbness in hands/feet	Dry or itchy eyes	WEIGHT AND EATING
<b>TOTAL (0-28)</b>	Blurred vision	Weight: <input style="width: 50px;" type="text"/> Height: <input style="width: 50px;" type="text"/>
SKIN	Dark circles or "bags"	Fluctuating weight
Blemishes, acne	Sensitivity to light	Food cravings
Rashes or hives	Night "blindness"/slow adjustment to the dark	Water retention
Eczema or psoriasis	<b>TOTAL (0-28)</b>	Binge eating or drinking
"Rosy" cheeks or flushing	GENITOURINARY/SEXUAL HEALTH	Purging (all methods)
Itchy skin	Frequent or nocturnal urination	Guilt or Anxiety with Eating
<b>TOTAL (0-20)</b>	Painful urination or Bedwetting	<b>TOTAL (0-24)</b>
EARS	Menstrual Clots, Cramps	OTHER SYMPTOMS, LIST:
Earache or ear infection	Breast pain	
Ringing in ears	PMS-hormone/mood issues	
Itchy ears	Hot flashes, Menopausal issues	
Discharge from ears	Loss of Libido; Fertility Issues	
Sensitivity to sound	<b>TOTAL (0-28)</b>	
<b>TOTAL (0-20)</b>		<b>TOTAL (0-20)</b>