Symptom Survey

Date:	Patient Name:	Patient Signature:

In order to provide our patients with the best possible care, please fill in the following form completely. Score every symptom based on your experience over the last 30 days, or since your last Symptom Survey, whichever was most recent. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for **every symptom** listed. Total the points for each category and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS:

●○○○○ = 0 = Don't Suffer From This Ever or Almost Ever
○●○○○ = 1 = Suffered OCCASSIONALLY (less than 2 times per week), symptom **wasn't severe**
○○●○○ = 2 = Suffered FREQUENTLY (2 or more times per week), symptom **wasn't severe**
○○○●○ = 3 = Suffered OCCASSIONALLY and symptom **was severe**
○○○○● = 4 = Suffered FREQUENTLY and symptom **was severe**

Grand Total:

CONSTITUTIONAL
○○○○○ Fatigue (sluggish, tired)
○○○○○ Hyperactive (nervous energy)
○○○○○ Restless (can't relax/sit still)
○○○○○ Sleepiness During Day
○○○○○ Insomnia at Night
○○○○○ Malaise (Feeling Lousy)
_____ TOTAL (0-24)

EMOTIONAL/MENTAL
○○○○○ Depression
○○○○○ Anxiety
○○○○○ Mood Swings
○○○○○ Irritability
○○○○○ Forgetfulness
○○○○○ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS
○○○○○ Migraine (any kind)
○○○○○ Headache (other than Migraine)
○○○○○ Earache
○○○○○ Ear Infection
○○○○○ Ringing in Ear
○○○○○ Itchy Ears
○○○○○ Discharge From Ears
_____ TOTAL (0-28)

SKIN
○○○○○ Blemishes, Acne
○○○○○ Rashes, Hives
○○○○○ Eczema
○○○○○ "Rosy" Cheeks
_____ TOTAL (0-16)

NASAL/SINUS
○○○○○ Post Nasal Drip
○○○○○ Sinus Pain
○○○○○ Runny Nose
○○○○○ Stuffy Nose
○○○○○ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT
○○○○○ Sore Throat
○○○○○ Swollen Throat
○○○○○ Swelling of Lips/Tongue
○○○○○ Gagging/Throat Clearing
○○○○○ Canker Sores
_____ TOTAL (0-20)

LUNGS
○○○○○ Wheezing
○○○○○ Chest Congestion
○○○○○ Dry Cough
○○○○○ Wet Cough
_____ TOTAL (0-16)

EYES
○○○○○ Red or Swollen Eyes
○○○○○ Watery Eyes
○○○○○ Itchy Eyes
○○○○○ Dark Circles" or "Bags"
_____ TOTAL (0-16)

GENITOURINARY
○○○○○ Increased Urinary Frequency
○○○○○ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL
○○○○○ Joint Pains/Aching
○○○○○ Stiff Joints
○○○○○ Muscle Aches
○○○○○ Stiff Muscles
_____ TOTAL (0-16)

CARDIOVASCULAR
○○○○○ Irregular Heartbeat
○○○○○ High Blood Pressure
_____ TOTAL (0-8)

DIGESTIVE
○○○○○ Heartburn/Reflux
○○○○○ Stomach Pains/Cramps
○○○○○ Intestinal Pains/Cramps
○○○○○ Constipation
○○○○○ Diarrhea
○○○○○ Bloating Sensation
○○○○○ Gas (of Any Kind)
○○○○○ Nausea, Vomiting
○○○○○ Painful Elimination
_____ TOTAL (0-36)

WEIGHT MANAGEMENT
_____ **Record Actual Weight**
○○○○○ Fluctuating Weight
○○○○○ Food Cravings
○○○○○ Water Retention
○○○○○ Binge Eating or Drinking
○○○○○ Purging (all methods)
_____ TOTAL (0-20)