

SYMPTOM SURVEY

Patient Name: _____ Date: _____

Instructions: The way to fill out the form is simple. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS listed below, write 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. After completion, turn in this form to your health care provider.

SCALE OF SYMPTOM POINTS: 0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	_____ INITIAL REPORT (or) _____ FOLLOW-UP (circle) 1 2 3 4 5 6 7	Grand Total:
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CONSTITUTIONAL

- _____ Fatigue (sluggish, tired)
- _____ Hyperactive (nervous energy)
- _____ Restless (can't relax/sit still)
- _____ Sleepiness During Day
- _____ Insomnia at Night
- _____ Malaise
- _____ TOTAL (0-20)

EMOTIONAL/MENTAL

- _____ Depression (feelings of hopelessness)
- _____ Anxiety (vague fears, uneasiness)
- _____ Mood Swings (rapid distinct changes)
- _____ Irritability
- _____ Forgetfulness
- _____ Lack of concentration/focus
- _____ TOTAL (0-24)

HEAD/EARS

- _____ Headache (any kind)
- _____ Earache
- _____ Ear Infection
- _____ Ringing in Ear
- _____ Itchy Ears
- _____ Discharge From Ears
- _____ TOTAL (0-24)

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
- _____ Lesions ("Canker Sores")
- _____ TOTAL (0-20)

LUNGS

- _____ Wheezing" (Asthma or Asthma-like Symptoms)
- _____ Chest Congestion
- _____ Non-Productive Coughing
- _____ Productive Coughing
- _____ TOTAL (0-20)

EYES

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

GENITOURINARY

- _____ 1 Increased Urinary Frequency
- _____ Painful Urination
- _____ TOTAL (0-8)

MUSCULOSKELETAL

- _____ Joint Pains/Aching
- _____ Stiff Joints
- _____ Muscle Aches
- _____ Stiff Muscles
- _____ TOTAL (0-20)

CARDIOVASCULAR

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

DIGESTIVE

- _____ Heartburn/Esoph.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**
- _____ **Approximate Height**
- _____ Fluctuating Weight
- _____ Food Cravings
- _____ Water Retention
- _____ Binge Eating or Drinking
- _____ Purging (all methods)
- _____ TOTAL (0-20)

Comments: