NAME: ________________________________ Date:______________________

Rate each of the following symptoms based upon your typical health profile over the last year.

Point Scale

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

Energy / Activity _______
Fatigue, sluggishness _______
Apathy, lethargy _______
Hyperactivity _______
Restlessness _______
Easy.fatiguability or lack of endurance _______
Headaches _______
Faintness _______
Dizziness _______
Insomnia _______
Subtotal _______

Emotional / Mental _______
Mood swings _______
Anxiety, fear or nervousness _______
Anger or irritability _______
Depression _______
Poor memory _______
Confusion, poor comprehension _______
Poor concentration _______
Difficulty in making decisions _______
Stuttering or stammering _______
Slurred speech _______
Learning disabilities _______
Subtotal _______

Ears/Mouth/Throat/Nose/Eyes _______
Itchy ears _______
Earaches, ear infections _______
Ringing in ears, hearing loss _______
Drainage from ear _______
Stuffy nose _______
Sinus problems _______
Hay fever _______
Excessive mucus formation, -post-nasal drip _______
Sneezing attacks _______
Poor night vision _______
Watery or itchy eyes _______
Swollen, tender or sticky eyelids _______
Bags or dark circles under eyes _______
Blurred or tunnel vision _______
(does not include near- or far-sightedness) _______
Chronic coughing _______
Sore Throat, hoarseness, loss of voice _______
Swollen or discolored tongue, gums, lips _______
Canker sores _______
Subtotal _______

Digestive Tract _______
Nausea or vomiting _______
Diarrhea _______
Constipation _______
Bloated feeling _______
Belching, or passing gas _______
Heartburn _______
Subtotal _______

Heart / Lungs _______
Irregular or skipped heartbeat _______
Rapid or pounding heartbeat _______
Chest pain _______
Chest congestion _______
Asthma, bronchitis _______
Shortness of breath _______
Subtotal _______

Joints / Muscles / Skin _______
Pain or aches in joints _______
Stiffness or limitation of movement _______
Pain or aches in muscles _______
Feeling of weakness or tiredness _______
Cramps in legs _______
Acne _______
Hives, rashes, or dry skin _______
Hair loss _______
Flushing or hot flashes _______
Fingernail abnormalities (spots, ridges) _______
Decreased sweating _______
Night sweats _______
Subtotal _______

Weight / Other _______
Binge eating/drinking _______
Craving certain foods _______
Excessive weight _______
Compulsive eating _______
Water retention _______
Underweight _______
Frequent illness _______
Frequent or urgent urination _______
Genital itch or discharge _______
Injury _______
Subtotal _______

Total Points _______