Confidential Symptom Questionnaire revised September 2013

Name: _____

Please use this scale to rate the frequency and severity of symptoms you have experienced <u>over the past two years</u>.
If multiple choices are given, please specify what applies in the comment column.

- ☐ Leave the score **blank** if you **Never** have the symptom.
- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild**.
- ☐ Use a **2** if you **Occasionally** have it and the effect is **Severe.**
- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
HEAD	Headache		
	Faintness		
	Dizziness		
	Insomnia If yes, difficulty falling asleep or staying asleep?		
NOSE	Stuffy nose		
	Sinus problems – Or sinus infections Antibiotic treatment?		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
MOUTH	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore throat, hoarseness, or loss of voice		
	Swollen or discolored tongue, gums, or lips		
	Chronic tooth/gum pain/ jaw pain. Which?		
	Canker sores		
SKIN	Acne – cystic?		
	Hives or other allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
	Flushing or hot flashes		
	Frequently feel cold? Where on your body?		
	Excessive sweating		
	Part of body frequently feeling numb. Which?		
HEART	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain		
LUNGS	Chest congestion		
	Asthma, bronchitis		
	Shortness of breath - Upon exertion or without exertion?		

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	Difficulty breathing		
DIGESTION	Nausea or vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Stomach pain How soon after waking do you eat breakfast?		
	Intestinal or other pain in GI tract? Where?		
JOINTS AND MUSCLES	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Tremor or restless leg		
	Feeling of weakness or tiredness		
WEIGHT	Binge eating/drinking		
	Craving certain foods		
	Excessive weight		
	Compulsive eating		
	Water retention		
	Underweight		
ENERGY	Fatigue, sluggishness		
	Apathy, lethargy		
	Hyperactivity		
	Restlessness		
MIND	Poor memory		
	Confusion, poor comprehension		
	Poor concentration or focus		
	Poor physical coordination		
	Difficulty in making decisions		
	Stuttering or stammering		
	Learning disabilities		
MOOD	Mood swings		
	Anxiety, fear, nervousness		
	Anger, irritability, aggressiveness		
	Depression		
	Other mood challenges?		

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	Frequent illness		
	Frequent or urgent urination		
	Inability to urinate or low urine flow		
	Low libido or other sexual concerns		
	Genital itch or discharge		
	Women: Breast fibroids		
	Women: Painful or tender breasts		
	Women: Uterine fibroids		
	Any surgeries/organs **removed**?		
OTHER	Any amalgam (silver) fillings? _____ Any root canals? _____ Any family history of alcoholism? _____ Where you delivered vaginally or by C-section? History of antibiotic use – What blood type are you? At what point in your life did you feel your healthiest?	_____ _____	_____
Please tally your scores for this update here:			**Total Symptom Score**

Any further comments you wish to share?

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