MEDICAL SYMPTOMS

TOTAL HEALTH SOLUTIONS

Name: _____ **Date:** _____

INSTRUCTIONS
Rate each of the following symptoms based upon your health profile for the past 30 days.

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

DIGESTIVE TRACT — Section Total

Nausea or vomiting	0	1	2	3	4	
Diarrhea	0	1	2	3	4	
Constipation	0	1	2	3	4	
Intestinal/stomach pain	0	1	2	3	4	
Bloated feeling	0	1	2	3	4	
Belching, passing gas	0	1	2	3	4	
Heartburn	0	1	2	3	4	_____

EARS

Itchy ears	0	1	2	3	4	
Earaches, ear infections	0	1	2	3	4	
Drainage from ear	0	1	2	3	4	
Ringing in ears, hearing loss	0	1	2	3	4	_____

EMOTIONS

Mood swings	0	1	2	3	4	
Anxiety, fear, or nervousness	0	1	2	3	4	
Anger, irritability, or aggressiveness	0	1	2	3	4	
Depression	0	1	2	3	4	_____

ENERGY/ACTIVITY

Fatigue, sluggishness	0	1	2	3	4	
Apathy, lethargy	0	1	2	3	4	
Hyperactivity	0	1	2	3	4	
Restlessness	0	1	2	3	4	_____

EYES

Watery or itchy eyes	0	1	2	3	4	
Swollen, reddened, or sticky eyelids	0	1	2	3	4	
Bags or dark circles under eyes	0	1	2	3	4	
Blurred or tunnel vision (not near/far sighted)	0	1	2	3	4	_____

HEAD

Headaches	0	1	2	3	4	
Faintness	0	1	2	3	4	
Dizziness	0	1	2	3	4	
Insomnia	0	1	2	3	4	_____

HEART

	0	1	2	3	4	
Irregular or skipped heartbeat	0	1	2	3	4	
Rapid or pounding heartbeat	0	1	2	3	4	
Chest pains	0	1	2	3	4	_____

JOINTS/MUSCLES

Pain or aches in joints	0	1	2	3	4	
Arthritis	0	1	2	3	4	
Stiffness or limitation of movement	0	1	2	3	4	
Feeling of weakness or tiredness	0	1	2	3	4	
Pain or aches in muscles	0	1	2	3	4	_____

MIND — Section Total

Poor memory	0	1	2	3	4	
Confusion, poor comprehension	0	1	2	3	4	
Poor concentration	0	1	2	3	4	
Poor physical coordination	0	1	2	3	4	
Difficulty in making decisions	0	1	2	3	4	
Stuttering or stammering	0	1	2	3	4	
Slurred speech	0	1	2	3	4	
Learning disabilities	0	1	2	3	4	_____

LUNGS

Chest congestion	0	1	2	3	4	
Asthma, bronchitis	0	1	2	3	4	
Shortness of breath	0	1	2	3	4	
Difficulty breathing	0	1	2	3	4	_____

MOUTH/THROAT

Gagging, frequent clearing of throat	0	1	2	3	4	
Sore throat, hoarseness, loss of voice	0	1	2	3	4	
Swollen discolored tongue, gums, lips	0	1	2	3	4	
Chronic coughing	0	1	2	3	4	
Canker sores	0	1	2	3	4	_____

NOSE

Excessive mucus formation	0	1	2	3	4	
Stuffy nose	0	1	2	3	4	
Sinus problems	0	1	2	3	4	
Hay fever	0	1	2	3	4	
Sneezing attacks	0	1	2	3	4	_____

SKIN

Acne	0	1	2	3	4	
Hives, rashes, dry skin	0	1	2	3	4	
Hair loss	0	1	2	3	4	
Flushing, hot flashes	0	1	2	3	4	
Excessive sweating	0	1	2	3	4	_____

WEIGHT

Binge eating or drinking	0	1	2	3	4	
Craving certain foods	0	1	2	3	4	
Excessive weight	0	1	2	3	4	
Compulsive eating	0	1	2	3	4	
Water retention	0	1	2	3	4	
Underweight	0	1	2	3	4	_____

OTHER

Frequent illness	0	1	2	3	4	
Frequent or urgent urination	0	1	2	3	4	
Genital itch or discharge	0	1	2	3	4	_____

GRAND TOTAL THIS PAGE _____

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