

HEALTH SURVEY

Rate each of the following symptoms based upon your health profile for the past 6 months:

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

DIGESTIVE

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloating feeling
___ Belching, passing gas
___ Heartburn
___ **TOTAL**

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears
___ Hearing loss
___ **TOTAL**

EMOTIONS

___ Mood swings
___ Anxiety, fear, nervousness
___ Anger, irritability
___ Depression
___ **TOTAL**

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
___ **TOTAL**

EYES

___ Water, itchy eyes
___ Swollen, reddened or sticky eyelids
___ Dark circles under eyes
___ Blurred or tunnel vision
___ **TOTAL**

HEART

___ Skipped heartbeats
___ Rapid heartbeats
___ Chest pain

___ **TOTAL**

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
___ **TOTAL**

MIND

___ Poor memory
___ Confusion
___ Poor concentration
___ Poor coordination
___ Difficulty making decisions
___ Stuttering, stammering
___ Slurred speech
___ Learning disabilities
___ **TOTAL**

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to Clear throat
___ Sore throat, hoarse
___ Swollen, discolored tongue, gums, or lips
___ Canker sores
___ **TOTAL**

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus
___ **TOTAL**

SKIN

___ Acne
___ Hives, rashes, dry skin
___ Hair loss
___ Flushing or hot flashes

___ Excessive sweating
___ **TOTAL**

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
___ **TOTAL**

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness, limited Movement
___ Pain, aches in muscles
___ Feeling of weakness or tiredness
___ **TOTAL**

WEIGHT

___ Binge eating or drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
___ **TOTAL**

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch, discharge
___ **TOTAL**

___ **GRAND TOTAL**

Add up the numbers to arrive at a total for each section to arrive at the grand total.

