Symptom Survey

Name: _____ Date: _____

Wt: _____

Instructions: Score EVERY symptom based on your experience OVER THE PAST MONTH FOR THE FIRST SURVEY, then the past week for follow-up surveys. Using the "Scale of Symptoms Points" listed below, fill in the appropriate score to the left of each symptom (blue boxes). The program will calculate your "Grand Total" at the top.
Also note the number of missed work/school days you have had in the last month due to illness.

Use the "Comments" section for anything not covered here; if you cheated on your program, if life had unexpected complications, if you noticed improvements in workouts/energy/sleep/health not covered; if you had an "a-ha!" moment, anything you want your Dietitian to know!

SCALE OF SYMPTOM POINTS:	**# Days Off Sick**	**Grand Total:**
0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), was MILD 2 = Suffer FREQUENTLY (2 or more times per week), was MILD 3 = Suffer OCCASSIONALLY and was SEVERE 4 = Suffer FREQUENTLY and was SEVERE		0

	CONSTITUTIONAL		NASAL/SINUS		MUSCULOSKELETAL
	Fatigue (sluggish, tired)		Post Nasal Drip		Joint Pains/Aching
	Hyperactive (nervous energy)		Sinus Pain		Stiff Joints
	Restless (can't relax/sit still)		Runny Nose		Muscle Aches
	Sleepiness During Day		Stuffy Nose		Stiff Muscles
	Insomnia at Night		Sneezing		Tics (facial or otherwise)
	Malaise		Seasonal Allergies		Muscle Spasms
	Seizures				Muscle Cramps
0	TOTAL (0-28)	0	TOTAL (0-24)	0	TOTAL (0-28)
	EMOTIONAL/MENTAL		**MOUTH/THROAT**		**DIGESTIVE**
	Depression (feelings of Hopelessness)		Sore Throat		Heartburn/Reflux
	Anxiety (vague fears, uneasiness)		Swollen Throat		Stomach Pains/Cramps
	Mood Swings (rapid distinct changes)		Swelling or burning of Lips/Tongue		Intestinal Pains/Cramps
	Irritability		Gagging/Throat Clearing		Constipation
	Forgetfulness		Lesions ("Canker Sores")		Diarrhea
	Lack of concentration/focus, brain fog		Difficulty Swallowing		Bloating Sensation
	Low sex drive	0	TOTAL (0-24)		Gas (of Any Kind)
0	TOTAL (0-28)		**LUNGS**		Nausea, Vomiting
	HEAD/EARS		Wheezing" (Asthma or Asthma-like Symptoms)		Vomiting
	Headache (not migraine)		Chest Congestion		Painful Elimination
	Migraine		Dry Cough		
	Earache		Wet Cough	0	TOTAL (0-40)
	Ear Infection		Shortness of Breath		**WEIGHT MANAGEMENT**
	Ringing in Ear	0	TOTAL (0-20)		Fluctuating Weight
	Itchy Ears		**EYES**		Food Cravings
	Discharge from ears		Red or Swollen Eyes		Water Retention
	Sensitivity to sounds		Watery Eyes		Binge Eating or Drinking
0	TOTAL (0-32)		Itchy Eyes		Purging (all methods)
	SKIN		Dark circles or "bags"	0	TOTAL (0-20)
	Blemishes, Acne		Sensitive to light		**GENITOURINARY**
	Rashes, Hives		Aura		Increased Urinary Frequency
	Eczema or psoriasis	0	TOTAL (0-24)		Painful Urination
	"Rosy" Cheeks		**CARDIOVASCULAR**		Bladder pain
	Flushing		Irregular Heartbeat		Bedwetting
	Itchy Skin		High Blood Pressure	0	TOTAL (0-16)
0	TOTAL (0-24)	0	TOTAL (0-8)		

Comments: