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. **If you are on a prescription medication for any symptom, that is automatically a 4** as it means the issue is severe enough to warrant medical intervention. For other symptoms, "severe" is anything that essentially interferes with your normal day-to-day, whethere by affecting your physical abilities or by affecting your mood and making you more tired or frustrated by the symptom.

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

Score	Symptom
	Fatigue (sluggish, tired)
	Hyperactive (nervous energy)
	Restless (can't relax/sit still)
	Sleepiness During Day
	Insomnia at Night
	Malaise
	Seizures
0	**TOTAL (0-28)**

EMOTIONAL/MENTAL

Score	Symptom
	Depression (feelings of Hopelessness)
	Anxiety (vague fears, uneasiness)
	Mood Swings (rapid distinct changes)
	Irritability
	Forgetfulness
	Lack of concentration/focus, brain fog
	Low sex drive
0	**TOTAL (0-28)**

HEAD/EARS

Score	Symptom
	Headache (not migraine)
	Migraine
	Earache
	Ear Infection
	Ringing in Ear
	Itchy Ears
	Discharge from ears
	Sensitivity to sounds
0	**TOTAL (0-32)**

SKIN

Score	Symptom
	Blemishes, Acne
	Rashes, Hives
	Eczema or psoriasis
	"Rosy" Cheeks
	Flushing
	Itchy Skin
0	**TOTAL (0-24)**

NASAL/SINUS

Score	Symptom
	Post Nasal Drip
	Sinus Pain
	Runny Nose
	Stuffy Nose
	Sneezing
	Seasonal Allergies
0	**TOTAL (0-24)**

MOUTH/THROAT

Score	Symptom
	Sore Throat
	Swollen Throat
	Swelling or burning of Lips/Tongue
	Gagging/Throat Clearing
	Lesions ("Canker Sores")
	Difficulty Swallowing
0	**TOTAL (0-24)**

LUNGS

Score	Symptom
	Wheezing" (Asthma or Asthma-like Symptoms)
	Chest Congestion
	Dry Cough
	Wet Cough
	Shortness of Breath
0	**TOTAL (0-20)**

EYES

Score	Symptom
	Red or Swollen Eyes
	Watery Eyes
	Itchy Eyes
	Dark circles or "bags"
	Sensitive to light
	Aura
0	**TOTAL (0-24)**

CARDIOVASCULAR

Score	Symptom
	Irregular Heartbeat
	High Blood Pressure
0	**TOTAL (0-8)**

MUSCULOSKELETAL

Score	Symptom
	Joint Pains/Aching
	Stiff Joints
	Muscle Aches
	Stiff Muscles
	Tics (facial or otherwise)
	Muscle Spasms
	Muscle Cramps
0	**TOTAL (0-28)**

DIGESTIVE

Score	Symptom
	Heartburn/Reflux
	Stomach Pains/Cramps
	Intestinal Pains/Cramps
	Constipation
	Diarrhea
	Bloating Sensation
	Gas (of Any Kind)
	Nausea, Vomiting
	Vomiting
	Painful Elimination
0	**TOTAL (0-40)**

WEIGHT MANAGEMENT

Score	Symptom
	Fluctuating Weight
	Food Cravings
	Water Retention
	Binge Eating or Drinking
	Purging (all methods)
0	**TOTAL (0-20)**

GENITOURINARY

Score	Symptom
	Increased Urinary Frequency
	Painful Urination
	Bladder pain
	Bedwetting
0	**TOTAL (0-16)**

Comments: