# Symptom Survey

| Date: | | Name: | | Dietitian: | |
|---|---|---|---|---|---|

Please rate the **intensity** and **frequency** of your symptoms using the **scale of symptom points** listed below. Score **every** symptom based on your **average experience weekly over the last month.**

**BLANK** = **NEVER** or **RARELY** have this symptom
**1** = Was **MILD** and **OCCASIONAL** (1 time per week or less)
**2** = Was **MILD** and **FREQUENT** (2 or more times per week)
**3** = Was **SEVERE** and **OCCASIONAL** (1 time per week or less)
**4** = Was **SEVERE** and **FREQUENT** (2 or more times per week)

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|---|---|
| **Grand Total Symptom Points:** | |
| **Number of Missed Work or School Days in Past Month:** | |

| | ENERGY/WELLNESS |
|---|---|
| | Fatigue (sluggish, tired) |
| | Low Energy, Tire quickly |
| | Restless (can't relax/sit still) |
| | Daytime sleepiness |
| | Insomnia at night |
| | Malaise (feeling lousy) |
| | TOTAL (0-24) |
| | **EMOTIONAL/MENTAL** |
| | Depression |
| | Anxiety (fears, uneasiness) |
| | Mood swings (rapid changes) |
| | Irritability |
| | Forgetfulness/Poor Memory |
| | Poor concentration/brain fog |
| | Low sex drive |
| | TOTAL (0-28) |
| | **NEUROLOGICAL** |
| | Headache (not migraine) |
| | Migraine/Aura (visual,other) |
| | Dizziness or vertigo |
| | Hyperactive (nervous energy) |
| | Confusion |
| | Tics/twitches, or seizures |
| | Tingling/Numbness in hands/feet |
| | TOTAL (0-28) |
| | **SKIN** |
| | Blemishes, acne |
| | Rashes or hives |
| | Eczema or psoriasis |
| | "Rosy" cheeks or flushing |
| | Itchy skin |
| | TOTAL (0-20) |
| | **EARS** |
| | Earache or ear infection |
| | Ringing in ears |
| | Itchy ears |
| | Discharge from ears |
| | Sensitivity to sound |
| | TOTAL (0-20) |

| | NASAL/SINUS |
|---|---|
| | Post nasal drip |
| | Sinus pain |
| | Runny nose |
| | Stuffy nose |
| | Sneezing |
| | TOTAL (0-20) |
| | **MOUTH/THROAT** |
| | Dry mouth |
| | Sore/Swollen throat or tongue |
| | Swelling/burning lips/tongue |
| | Gagging/throat clearing |
| | Canker sores, mouth sores |
| | Difficulty swallowing |
| | TOTAL (0-24) |
| | **LUNGS** |
| | Wheezing |
| | Chest congestion |
| | Chronic cough, wet or dry |
| | Shortness of breath |
| | TOTAL (0-16) |
| | **EYES** |
| | Red or swollen eyes |
| | Watery eyes |
| | Dry or itchy eyes |
| | Blurred vision |
| | Dark circles or "bags" |
| | Sensitivity to light |
| | Night "blindness"/slow adjustment to the dark |
| | TOTAL (0-28) |
| | **GENITOURINARY/SEXUAL HEALTH** |
| | Frequent or nocturnal urination |
| | Painful urination or Bedwetting |
| | Menstrual Clots, Cramps |
| | Breast pain |
| | PMS-hormone/mood issues |
| | Hot flashes, Menopausal issues |
| | Loss of Libido; Fertility Issues |
| | TOTAL (0-28) |

| | MUSCULOSKELETAL |
|---|---|
| | Stiff or painful joints |
| | Stiff or achy muscles |
| | Muscle spasms or cramps |
| | TOTAL (0-12) |
| | **CARDIOVASCULAR** |
| | Irregular heartbeat |
| | Rapid heartbeat (tachycardia) |
| | High blood pressure |
| | Cold hands/feet |
| | TOTAL (0-16) |
| | **DIGESTIVE** |
| | Heartburn/reflux |
| | Spasms of the esophagus |
| | Stomach pains/cramps |
| | Intestinal pains/cramps |
| | Constipation |
| | Diarrhea |
| | Painful elimination |
| | Bloating sensation |
| | Gas (of any kind) |
| | Nausea |
| | Vomiting |
| | TOTAL (0-44) |
| | **WEIGHT AND EATING** |
| Weight: | Height: |
| | Fluctuating weight |
| | Food cravings |
| | Water retention |
| | Binge eating or drinking |
| | Purging (all methods) |
| | Guilt or Anxiety with Eating |
| | TOTAL (0-24) |
| | **OTHER SYMPTOMS, LIST:** |
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| | |
| | TOTAL (0-20) |