REBECCASNOW

Medical Symptom Questionnaire

Name:

Date:

Please rate your symptoms according to the following rating system. At the end of each category, calculate the total and use these totals to calculate a grand total.

Rating Scale:
0 = Nearly never experience the symptom
1 = Occasionally experience it, and it is not severe
2 = Occasionally experience it, and it is severe
3 = Regularly experience it, and it is not severe
4 = Regularly experience it, and it is severe

DIGESTIVE
___ Nausea, vomiting
___ Diarrhea
___ Constipation
___ Bloating
___ Belching, passing gas
___ Heartburn
___ Intestinal/Stomach pain
Total _____

EARS
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
Total _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing
___ Excessive mucus formation
Total _____

EMOTIONS
___ Mood swings
___ Anxiety, fear, nervousness
___ Anger, irritability, aggressiveness
___ Depression
Total _____

EYES
___ Watery, itchy eyes
___ Swollen, reddened, sticky eyelids
___ Dark circles under eyes
___ Blurred or tunnel vision*
*Does not include near or farsightedness
Total _____

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent clearing of throat
___ Sore throat, hoarsenss, loss of voice
___ Swollen/discolored tongue,lips,gum
___ Canker sores
Total _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
Total _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total _____

JOINTS/MUSCLES
___ Pain, aches in joints
___ Arthritis
___ Stiffness, limitation of movement
___ Pain, aches in muscles
___ Feeling of weakness, tiredness
Total _____

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital discharge
Total _____

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
Total _____

SKIN
___ Acne
___ Hives, rashes, dry skin
___ Hair loss
___ Flushing, hot flashes
___ Excessive sweating
Total _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
Total _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing
Total _____

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
Total _____

GRAND TOTAL: _____