

# Initial Symptom Survey

Date:	Patient Name:	Dietitian:
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**INSTRUCTIONS:** Score every symptom based on your experience **OVER THE PAST MONTH**. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed. Note score in the boxes to the left of symptoms. Also note the number of missed work days in the last month due to illness.

### SCALE OF SYMPTOM POINTS

**IF you did not suffer from the symptom ever or almost never, leave it blank.**  
 1 = **OCCASIONALLY** (less than 2 times per week), and symptom was **MILD**  
 2 = **FREQUENTLY** (2 or more times per week), and symptom was **MILD**  
 3 = **OCCASIONALLY** (less than 2 times per week), and symptom was **SEVERE**  
 4 = **FREQUENTLY** (2 or more times per week), and symptom was **SEVERE**

<b>Grand Total:</b>	<b># Missed Work Days</b>

<b>CONSTITUTIONAL</b>	<b>NASAL/SINUS</b>	<b>MUSCULOSKELETAL</b>
Fatigue (sluggish, tired)	Post nasal drip	Joint pains
Hyperactive (nervous energy)	Sinus pain	Stiff joints
Restless (can't relax/sit still)	Runny nose	Muscle aches
Daytime sleepiness	Stuffy nose	Stiff muscles
Insomnia at night	Sneezing	Ticks (facial or otherwise)
Malaise (feeling lousy)	<b>TOTAL (0-20)</b>	Muscle spasms
Seizures	<b>MOUTH/THROAT</b>	Muscle cramps
<b>TOTAL (0-28)</b>	Sore throat	<b>TOTAL (0-28)</b>
<b>EMOTIONAL/MENTAL</b>	Swollen throat	<b>CARDIOVASCULAR</b>
Depression	Swelling/burning lips/tongue	Irregular heartbeat
Anxiety (fears, uneasiness)	Gagging/throat clearing	High blood pressure
Mood swings (rapid changes)	Canker sores	<b>TOTAL (0-8)</b>
Irritability	Difficulty swallowing	<b>DIGESTIVE</b>
Forgetfulness	<b>TOTAL (0-24)</b>	Heartburn/reflux
Lack of concentration/Brain fog	<b>LUNGS</b>	Stomach pains/cramps
Low sex drive	Wheezing	Intestinal pains/cramps
<b>TOTAL (0-28)</b>	Chest congestion	Constipation
<b>HEAD/EARS</b>	Dry cough	Diarrhea
Headache (not migraine)	Wet cough	Bloating sensation
Migraine	Shortness of breath	Gas (of any kind)
Earache	<b>TOTAL (0-20)</b>	Nausea
Ear infection	<b>EYES</b>	Vomiting
Ringing in ears	Red or swollen eyes	Painful elimination
Itchy ears	Watery eyes	<b>TOTAL (0-40)</b>
Discharge from ears	Itchy eyes	<b>WEIGHT MANAGEMENT</b>
Sensitivity to sound	Dark circles or "bags"	Current weight:
<b>TOTAL (0-32)</b>	Sensitivity to light	Fluctuating weight
<b>SKIN</b>	Aura	Food cravings
Blemishes, acne	<b>TOTAL (0-24)</b>	Water retention
Rashes or hives	<b>GENITOURINARY</b>	Binge eating or drinking
Eczema or psoriasis	Increased urinary frequency	Purging (all methods)
"Rosy" cheeks	Painful urination	<b>TOTAL (0-20)</b>
Flushing	Bladder pain	<b>LIST OTHER SYMPTOMS:</b>
Itchy skin	Bedwetting	
<b>TOTAL (0-24)</b>	<b>TOTAL (0-16)</b>	