

Patient Name: _____

Date: _____

INSTRUCTIONS: Using the “Scale of Symptom Points” listed to the right, score every symptom based on your experience OVER THE PAST 30 DAYS, then subtotal each category. Add the subtotals and record the “Grand Total” at the bottom of the form.

Scale of Symptom Points

Leave blank if you DID NOT experience the symptom

1 = Mild and Occasional (less than 2 times per week)

2 = Mild and Frequent (2 or more times per week)

3 = Severe and Occasional (less than 2 times per week)

4 = Severe and Frequent (2 or more times per week)

CONSTITUTIONAL

Fatigue _____
Hyperactive _____
Restless _____
Daytime sleepiness _____
Insomnia at night _____
Malaise (feeling lousy) _____
Seizures _____

TOTAL (0-28) _____

EMOTIONAL/MENTAL

Depression _____
Anxiety _____
Mood swings _____
Irritability _____
Forgetfulness _____
Lack of concentration _____
Brain fog _____
Low sex drive _____

TOTAL (0-32) _____

HEAD/EARS

Headache (not migraine) _____
Migraine _____
Earache _____
Ear infection _____
Ringing in ears _____
Itchy ears _____
Discharge from ears _____
Sensitivity to sound _____

TOTAL (0-32) _____

SKIN

Blemishes, acne _____
Rashes or hives _____
Eczema _____
Psoriasis _____
“Rosy” cheeks _____
Flushing _____
Itchy skin _____

TOTAL (0-28) _____

NASAL/SINUS

Post nasal drip _____
Sinus pain _____
Runny nose _____
Stuffy nose _____
Sneezing _____

TOTAL (0-20) _____

MOUTH/THROAT

Sore throat _____
Swollen throat _____
Burning lips/tongue _____
Swelling lips/tongue _____
Gagging/throat clearing _____
Canker sores _____
Difficulty swallowing _____

TOTAL (0-28) _____

LUNGS

Wheezing _____
Chest congestion _____
Dry cough _____
Wet cough _____
Shortness of breath _____

TOTAL (0-20) _____

EYES

Red or swollen eyes _____
Watery eyes _____
Itchy eyes _____
Dark circles or “bags” _____
Sensitivity to light _____
Aura _____

TOTAL (0-24) _____

GENITOURINARY

Increased urinary frequency _____
Painful urination _____
Bladder pain _____
Bedwetting _____

TOTAL (0-16) _____

MUSCULOSKELETAL

Joint pains _____
Stiff joints _____
Muscle aches _____
Stiff muscles _____
Tics (facial or otherwise) _____
Muscle spasms _____
Muscle cramps _____

TOTAL (0-28) _____

CARDIOVASCULAR

Irregular heartbeat _____
High blood pressure _____

TOTAL (0-8) _____

DIGESTIVE

Heartburn/reflux _____
Stomach pains/cramps _____
Intestinal pains/cramps _____
Constipation _____
Diarrhea _____
Bloating sensation _____
Gas (of any kind) _____
Nausea _____
Vomiting _____

Painful elimination _____

TOTAL (0-40) _____

WEIGHT MANAGEMENT

Current weight: _____
Fluctuating weight _____
Food cravings _____
Water retention _____
Binge eating or drinking _____
Purging (all methods) _____

TOTAL (0-20) _____

GRAND TOTAL _____

Follow-up Symptom Survey

Patient Name: _____

Date: _____

On a scale of 1 to 10, how closely did you follow your eating plan this week?

1 2 3 4 5 6 7 8 9 10

Not at all ◀ (Circle Number) ▶ Perfect Adherence

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TOTAL (0-40) _____

WEIGHT MANAGEMENT

Current weight: _____
Fluctuating weight _____
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Water retention _____
Binge eating or drinking _____
Purging (all methods) _____

TOTAL (0-20) _____

LIST OTHER SYMPTOMS:

GRAND TOTAL _____