LEAP Initial Symptom Survey

LIFESTYLE EATING AND PERFORMANCE

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)	0

EMOTIONAL/MENTAL

Depression	
Anxiety	
Mood swings	
Irritability	
Forgetfulness	
Lack of concentration	
Brain fog	
Low sex drive	
TOTAL (0-32)	0

HEAD/EARS

Headache (not migraine)	
Migraine	
Earache	
Ear infection	
Ringing in ears	
Itchy ears	
Discharge from ears	
Sensitivity to sound	
TOTAL (0-32)	0

SKIN

Blemishes, acne	
Rashes or hives	
Eczema	
Psoriasis	
"Rosy" cheeks	
Flushing	
Itchy skin	
TOTAL (0-28)	0

NASAL/SINUS

Post nasal drip	
Sinus pain	
Runny nose	
Stuffy nose	
Sneezing	
TOTAL (0-20)	0

MOUTH/THROAT

Sore throat	
Swollen throat	
Burning lips/tongue	
Swelling lips/tongue	
Gagging/throat clearing	
Canker sores	
Difficulty swallowing	
TOTAL (0-28)	0

LUNGS

Wheezing	
Chest congestion	
Dry cough	
Wet cough	
Shortness of breath	
TOTAL (0-20)	0

EYES

Red or swollen eyes	
Watery eyes	
Itchy eyes	
Dark circles or "bags"	
Sensitivity to light	
Aura	
TOTAL (0-24)	0

GENITOURINARY

Increased urinary frequency	
Painful urination	
Bladder pain	
Bedwetting	
TOTAL (0-16)	0

MUSCULOSKELETAL

Joint pains	
Stiff joints	
Muscle aches	
Stiff muscles	
Tics (facial or otherwise)	
Muscle spasms	
Muscle cramps	
TOTAL (0-28)	0

CARDIOVASCULAR

Irregular heartbeat	
High blood pressure	
TOTAL (0-8)	0

DIGESTIVE

Heartburn/reflux	
Stomach pains/cramps	
Intestinal pains/cramps	
Constipation	
Diarrhea	
Bloating sensation	
Gas (of any kind)	
Nausea	
Vomiting	
Painful elimination	
TOTAL (0-40)	0

WEIGHT MANAGEMENT

Current weight:_____	
Fluctuating weight	
Food cravings	
Water retention	
Binge eating or drinking	
Purging (all methods)	
TOTAL (0-20)	0

GRAND TOTAL 0

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LEAP Follow-up Symptom Survey

LIFESTYLE EATING AND PERFORMANCE

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 Adherance

INSTRUCTIONS: Using the "Scale of Symptom Points" listed to the right, score every symptom based on your experience OVER THE PAST WEEK, 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) _____

LIST OTHER SYMPTOMS:

_____
_____
_____

GRAND TOTAL _____

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