Patient Name _____   Date _____   Weight _____

Symptom Survey Questionnaire

Simply rate each of the following symptoms from zero to four. Add up your points, if you score 14 or more (or 10 or more in any one category) you are a great candidate for this program. Please be totally honest, this is your health! Enter one of the following numbers next to each symptom.

0 – Never or almost never have the symptom
1 – Occasionally has it, effect is not severe
2 – Occasionally has it, effect is severe

3 – Frequently has it, effect is not severe
4 – Frequently has it, effect is severe

Digestive

	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Belching, passing gas
	Heartburn
	Total Score

Emotions

	Mood swings
	Anxiety, fear, nervous
	Anger, irritability
	Depression
	Total Score

Eyes

	Watery, itchy eyes
	Swollen, reddened, sticky eyelids
	Dark circles under eyes
	Blurred, tunnel vision
	Total Score

Lungs

	Chest congestion
	Asthma, bronchitis
	Shortness of breath
	Difficulty breathing
	Total Score

Mind

	Poor Memory
	Confusion
	Poor concentration
	Poor coordination
	Difficulty making decisions
	Stuttering, stammering
	Slurred speach
	Learning disabilties
	Total Score

Energy/Activity

	Fatigue, sluggishness
	Apathy
	Hyperactivity
	Restlessness
	Total Score

Head

	Headaches
	Faintness
	Dizziness
	Insomnia
	Total Score

Ears

	Itchy ears
	Earaches, ear infections
	Drainage from ears
	Ringing in ears, hearing loss
	Total Score

Mouth - Throat

	Chronic coughing
	Gagging, need to clear throat
	Sore throat, hoarse
	Swollen or discolored tongue, gums or lips
	Canker sores
	Total Score

Skin

	Acne
	Hives, rashes, dry skin
	Hair loss
	Flushing, hot flashes
	Excessive sweating
	Total Score

Joints - Muscles

	Pain or aches in joints
	Arthritis
	Stiff, limited movement
	Pain, aches in muscles
	Weakness or tiredness
	Total Score

Nose

	Stuffy nose
	Sinus problems
	Hay fever, allergies
	Sneezing attacks
	Excessive mucus
	Total Score

Heart

	Skipped heartbeats
	Rapid heartberats
	Chest pain
	Total Score

Weight

	Binge eating/drinking
	Craving certain foods
	Excessive weight gain
	Compulsive eating
	Water retention
	Underweight
	Total Score

Other

	Frequent illness
	Frequent, urgent urination
	Genital itch, discharge
	Total Score

Add the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If you score 14 or more (or 10 or more in any one category) you are a great candidate for this program

Grand Total _____