HEALTH SURVEY

Rate each of the following symptoms based upon your health profile for the past 6 months:

Point Scale:
0 = NEVER or ALMOST NEVER have the symptom
1 = OCCASIONALLY have it, effect is NOT SEVERE
2 = OCCASIONALLY have it, effect is SEVERE
3 = FREQUENTLY have it, effect is NOT SEVERE
4 = FREQUENTLY have it, effect is SEVERE

DIGESTIVE
____Nausea or vomiting
____Diarrhea
____Constipation
____Bloated feeling
____Belching, passing gas
____Heartburn
____**TOTAL**

EARS
____Itchy ears
____Earaches, ear infections
____Drainage from ear
____Ringing in ears
____Hearing loss
____**TOTAL**

EMOTIONS
____Mood swings
____Anxiety, fear, nervousness
____Anger, irritability
____Depression
____**TOTAL**

ENERGY/ACTIVITY
____Fatigue, sluggishness
____Apathy, lethargy
____Hyperactivity
____Restlessness
____**TOTAL**

EYES
____Water, itchy eyes
____Swollen, reddened or sticky eyelids
____Dark circles under eyes
____Blurred or tunnel vision
____**TOTAL**

HEART
____Skipped heartbeats
____Rapid heartbeats
____Chest pain

LUNGS
____Chest congestion
____Asthma, bronchitis
____Shortness of breath
____Difficulty breathing
____**TOTAL**

MIND
____Poor memory
____Confusion
____Poor concentration
____Poor coordination
____Difficulty making decisions
____Stuttering, stammering
____Slurred speech
____Learning disabilities
____**TOTAL**

MOUTH/THROAT
____Chronic coughing
____Gagging, frequent need to Clear throat
____Sore throat, hoarse
____Swollen, discolored tongue, gums, or lips
____Canker sores
____**TOTAL**

NOSE
____Stuffy nose
____Sinus problems
____Hay fever
____Sneezing attacks
____Excessive mucus
____**TOTAL**

SKIN
____Acne
____Hives, rashes, dry skin
____Hair loss
____Flushing or hot flashes
____Excessive sweating

HEAD
____Headaches
____Faintness
____Dizziness
____Insomnia
____**TOTAL**

JOINTS/MUSCLES
____Pain or aches in joints
____Arthritis
____Stiffness, limited Movement
____Pain, aches in muscles
____Feeling of weakness or tiredness
____**TOTAL**

WEIGHT
____Binge eating or drinking
____Craving certain foods
____Excessive weight
____Compulsive eating
____Water retention
____Underweight
____**TOTAL**

OTHER
____Frequent illness
____Frequent or urgent urination
____Genital itch, discharge
____**TOTAL**

_____**GRAND TOTAL**

Add up the numbers to arrive at a total for each section to arrive at the grand total.