Health Symptoms Questionnaire

Name: _____ Date: _____

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely 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 Tract	Nausea, vomiting	⓪	①	②	③	④
	Diarrhea	⓪	①	②	③	④
	Constipation	⓪	①	②	③	④
	Bloated feeling	⓪	①	②	③	④
	Heartburn	⓪	①	②	③	④
	Intestinal, stomach pain	⓪	①	②	③	④
	Digestive Total:		o			
Joints/Muscles	Pain or aches in joints	⓪	①	②	③	④
	Arthritis, joint swelling	⓪	①	②	③	④
	Stiff or limitation of movement	⓪	①	②	③	④
	Pain or aches in muscles	⓪	①	②	③	④
	Feeling of weakness or tired	⓪	①	②	③	④
	Joints/Muscles Total:		o			
Emotional	Mood swings	⓪	①	②	③	④
	Anxiety, fear, nervousness	⓪	①	②	③	④
	Anger, irritability, aggression	⓪	①	②	③	④
	Depression	⓪	①	②	③	④
	Emotional Total:		o			
Weight/Food	Binge eating, drinking	⓪	①	②	③	④
	Craving certain foods	⓪	①	②	③	④
	Excessive weight	⓪	①	②	③	④
	Compulsive eating, food addictions	⓪	①	②	③	④
	Water retention	⓪	①	②	③	④
	Underweight	⓪	①	②	③	④
	Weight/Food Total:		o			
Energy/Sleep	Fatigue, sluggishness	⓪	①	②	③	④
	Apathy, lethargy	⓪	①	②	③	④
	Hyperactivity	⓪	①	②	③	④
	Restlessness, achiness	⓪	①	②	③	④
	Sleep disturbances	⓪	①	②	③	④
	Energy/Sleep Total:		o			
Skin	Acne	⓪	①	②	③	④
	Hives, rashes, dry skin, redness	⓪	①	②	③	④
	Hair loss	⓪	①	②	③	④
	Flushing, hot flashes	⓪	①	②	③	④
	Excessive sweating	⓪	①	②	③	④
	Skin Total:		o			
Heart	Irregular or skipped heartbeat	⓪	①	②	③	④
	Rapid or pounding heartbeat	⓪	①	②	③	④
	Chest pain	⓪	①	②	③	④
	Heart Total:		o			
Other	Frequent illness	⓪	①	②	③	④
	Frequent or urgent urination	⓪	①	②	③	④
	Genital itch or discharge	⓪	①	②	③	④
	Other Total:		o			

Respiratory	Chest congestion	⓪	①	②	③	④
	Asthma, bronchitis	⓪	①	②	③	④
	Shortness of breath	⓪	①	②	③	④
	Difficulty breathing	⓪	①	②	③	④
	Respiratory Total:		o			
Eyes	Watery or itchy eyes	⓪	①	②	③	④
	Swollen, red, or sticky eyelids	⓪	①	②	③	④
	Bags or dark circles under eyes	⓪	①	②	③	④
	Blurred or restricted vision	⓪	①	②	③	④
	Eyes Total:		o			
Nose	Stuffy nose	⓪	①	②	③	④
	Sinus problems or dripping nose	⓪	①	②	③	④
	Hay fever	⓪	①	②	③	④
	Sneezing attacks	⓪	①	②	③	④
	Excessive mucus	⓪	①	②	③	④
	Nose Total:		o			
Mouth/Throat	Frequent, consistent coughing	⓪	①	②	③	④
	Gagging, need to clear throat	⓪	①	②	③	④
	Sore throat, hoarse, loss of voice	⓪	①	②	③	④
	Swollen or discolored tongue, gums, or lips	⓪	①	②	③	④
	Canker sores, other mouth sores	⓪	①	②	③	④
	Mouth/Throat Total:		o			
Ears	Itchy ears	⓪	①	②	③	④
	Earaches, ear infections	⓪	①	②	③	④
	Drainage from ear, waxy buildup	⓪	①	②	③	④
	Ringing in ears, hearing loss	⓪	①	②	③	④
	Ears Total:		o			
Head	Headaches	⓪	①	②	③	④
	Faintness or lightheadedness	⓪	①	②	③	④
	Dizziness	⓪	①	②	③	④
	Head Total:		o			
Cognitive	Poor memory, recall	⓪	①	②	③	④
	Confusion, poor comprehension	⓪	①	②	③	④
	Poor concentration	⓪	①	②	③	④
	Poor physical coordination	⓪	①	②	③	④
	Difficulty making decisions	⓪	①	②	③	④
	Stuttering, stammering	⓪	①	②	③	④
	Slurred speech	⓪	①	②	③	④
	Learning disabilities	⓪	①	②	③	④
	Cognitive Total:		o			

Grand Total _____

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