Symptom Inventory #_____

Patient Name: _____
Date: _____ Age: _____Weight:_____

Symptom Point Scale:
0- Never
1- occasionally
2- occasionally with severe symptoms
3- frequently
4- frequently with severe symptoms

Date Wellness Program Started: _____
Followed Wellness Program: ____Exactly ____Mostly ____Hardly ___ Never

Enter Total Score and use to compare with future Symptom Inventory
Total Score: _____

Head
___Headaches
___Dizziness
___Sleep disorders
___Face flushing
___Total

Ears
___Itchy ears
___Ear aches/infections
___Ringing in ears
___Hearing loss
___Reddening of ears
___Total

Nose
___Stuffy nose
___Red/inflamed nose
___Sinus problems
___Hay fever
___Sneezing
___Total

Eyes
___Watery
___Itchy
___Red/swollen
___Dark circles
___Blurry vision
___Total

Mouth and Throat
___Chronic coughing
___Clear throat often
___Sore throat
___Swollen lips
___Canker sores
___Itching
___Hoarse/loss voice
___Total

Skin
___Acne
___Itching
___Hives/rash
___Dry skin
___Hot flashes
___Total

Digestion
___Nausea
___Diarrhea
___Constipation
___Bloated feeling
___Stomach
___Vomiting
___Blood/mucous in stool
___Total

Energy
___Lethargic
___Fatigue
___Hyperactive
___Restlessness
___Total

Muscles and Joints
___Arthritis
___Stiffness
___Pain or aches in joints
___Pain or aches in muscles
___Weak or tired
___Growing pains
___Total

Emotions
___Mood swings
___Anxiety/fear
___Irritable/aggressive
___Cries easily
___Depressed
___Total

Weight
___Binge eating
___Craving certain foods
___Compulsive eating
___Overweight
___Water retention
___Total

Heart
___Irregular heartbeat
___Rapid heartbeat
___Chest pain
___Chest pounding
___Total

Lungs
___Congestion
___Persistent cough
___Asthma/bronchitis
___Shortness of breath
___Wheezing
___Total

Mind
___Poor memory
___Learning disabilities
___Difficulty completing task
___Short attention span
___Confusion
___Total