SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile. Select the number that best corresponds to the frequency and severity of the symptoms as noted below:

0 = Never or almost never have the symptoms
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

Afterwards add up the numbers to arrive at a total for each section and add it in the proper box. Then, add the totals for each section to arrive at the grand total, which we will ask for at the end of the questionnaire.

NAME

E-MAIL

DATE

DIGESTIVE COLON

Feeling that bowels do not empty completely	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Alternating constipation and diarrhea	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Diarrhea	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Constipation	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Lower abdominal pain relieved by passing stool or gas	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Pass large amount of foul-smelling gas	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Hard, dry or small stool	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **DIGESTIVE COLON** section. It should range from 0 to 24

Total Score 0

ENERGY AND ACTIVITY

Fatigue or sluggishness	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Apathy	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Hyperactivity	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Restlessness	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **ENERGY AND ACTIVITY** section. It should range from 0 to 16

Total Score 0

JOINT AND MUSCLE

Pain or aches in joints	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Arthritis	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Stiff or limited movement	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Pain or aches in muscle	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Weakness or tiredness	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **JOINTS AND MUSCLE** section. It should range from 0 to 20

Total Score 0

EMOTIONS

Mood swings	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Anxiety or fear or nervousness	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Anger or irritability	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Depression	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **EMOTIONS** section. It should range from 0 to 16

Total Score 0

HEAD

Headaches	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Fainting	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Dizziness	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Insomnia	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **HEAD** section. It should range from 0 to 16

Total Score 0

NOSE

Stuffy nose	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Sinus problems	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Hay fever or allergies	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Sneezing attacks	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Excessive mucus	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **NOSE** section. It should range from 0 to 20

Total Score 0

EYES

Watery or itchy eyes	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Swollen or reddened or sticky eyelids	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Dark circles under eyes	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Blurred vision or tunnel vision	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **EYES** section. It should range from 0 to 16

Total Score 0

EARS

Itchy ears	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Earaches or ear infections	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Drainage from ears	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Ringing in ears or hearing loss	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **EARS** section. It should range from 0 to 16

Total Score 0

HEART

Skipped heartbeats	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Rapid heartbeats	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Chest pain	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **HEART** section. It should range from 0 to 12

Total Score 0

LUNGS

Chest congestion	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Asthma or bronchitis	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Shortness of breath	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Difficulty breathing	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **LUNGS** section. It should range from 0 to 16

Total Score 0

MOUTH OR THROAT

Chronic coughing	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Gagging or needing to clear throat	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Sore throat or hoarse voice	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Swollen or discolored tongue or gums or lips	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Canker sores	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **MOUTH AND THROAT** section. It should range from 0 to 20

Total Score 0

WEIGHT

Binge eating or drinking	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Craving certain foods	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Excessive weight gain	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Compulsive eating	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Water retention	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Underweight	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **WEIGHT** section. It should range from 0 to 24

Total Score 0

MIND

Poor memory	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Confusion	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Poor concentration	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Difficulty making decisions	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Stuttering or stammering	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Slurred speech	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Learning disabilities	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **MIND** section. It should range from 0 to 32

Total Score 0

OTHER

Acne	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Hives or rashes or dry skin	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Hair loss	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Flushing or hot flashes	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Excessive sweating	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Use laxatives frequently	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Coated tongue or “fuzzy” debris on tongue	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
More than 3 bowel movements daily	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Increasing frequency of food reactions	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Unpredictable food reactions	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

This is the sum of the numbers you selected in the **OTHER** section. It should range from 0 to 20

Total Score 0

GRAND TOTAL

This is the sum of your **TOTAL SCORES**. It should range From 0 to 208. The greater the score, the more severe your condition

Total Score 0

SUBMIT