Patient Name: ____ Date: ______________________

Instructions: Start with the first symptom and ask yourself, "over the last 6 months, have I experienced this symptom?" If you answer no or almost not at all, then mark a "0". If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). Ask yourself if the symptom is "severe" or "not severe". Using the SCALE OF SYMPTOM POINTS listed below, write the appropriate score in the corresponding field for EVERY symptom listed.

SCALE OF SYMPTOM POINTS:

0 = Do not suffer from this ever or almost ever
1 = Suffer OCCASIONALLY (<2 times per week), is not severe
2 = Suffer FREQUENTLY (2 or more times per week), not severe
3 = Suffer OCCASIONALLY and is severe
4 = Suffer FREQUENTLY and is severe

CONSTITUTIONAL

_____ Fatigue (sluggish, tired)
_____ Hyperactive (nervous energy)
_____ Restless (can't relax/sit still)
_____ Sleepiness During Day
_____ Insomnia At Night
_____ Dizziness

EMOTIONAL/MENTAL

_____ Depression
_____ Anxiety (vague fears, uneasiness)
_____ Mood Swings (rapid distinct changes)
_____ Irritability
_____ Forgetfulness

HEAD/EARS

_____ Headache (any kind)
_____ Earache
_____ Ear Infection
_____ Ringing In Ear
_____ Itchy Ears
_____ Discharge From Ears

SKIN

_____ Blemishes, Acne
_____ Rashes, Hives
_____ Eczema
_____ "Rosy" Cheeks

NASAL/SINUS

_____ Postnasal Drip
_____ Sinus Pain
_____ Runny Nose
_____ Stuffy Nose
_____ Sneezing

MUSCOLOSKELETAL

_____ Joint Pains/Aching
_____ Stiff Joints
_____ Muscle Aches
_____ Stiff Muscles
_____ Arthritis (diagnosed)

CARDIOVASCULAR

_____ Irregular Heartbeat
_____ High Blood Pressure

DIGESTIVE

_____ Heartburn/Esophageal Reflux
_____ Stomach Pains/Cramps
_____ Intestinal Pains/Cramps
_____ Constipation
_____ Diarrhea
_____ Bloating Sensation
_____ Gas (of any kind)
_____ Nausea, Vomiting
_____ Painful Elimination

WEIGHT MANAGEMENT

_____ **Approximate Weight**
_____ **Approximate Height**
_____ Fluctuating Weight

OTHER

_____ Leg Cramp When Sitting
_____ Feet Get Cold Or Numb
_____ Legs Hurt Walking A Lot
_____ Sores – Legs Not Healing
_____ Tingling In The Legs
_____ Sleeping Difficulties

Please circle the following symptoms (if any) that you may experience or have experienced in the past 60 days:

Dizziness, Light Headedness, "Weak Spells", Fainting, "Pounding in the Chest", Palpitations, Fluttering or Flip Flop, Chest Pain, Tightness, Heaviness in the Chest, Indigestion-Like Pain, Shortness of Breath, Sensations of Choking, Intermittent Jaw Pain, Tingling Arm, Back Pain Between Shoulder Blades, Wheezing

1. Have any of your immediate family members had heart disease? [ ] YES [ ] NO
2. Have any of your immediate family members had diabetes? [ ] YES [ ] NO
3. Have you recently started or stopped smoking? [ ] YES [ ] NO
4. Have you recently started an exercise program? [ ] YES [ ] NO
5. Have you fallen in the last year due to dizziness or vertigo? [ ] YES [ ] NO
6. Have you gotten dizzy after standing up quickly on multiple occasions? [ ] YES [ ] NO

Patient Signature: ____ Date: _______________________________

Physician Signature: ____