

## 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  
\_\_\_ Bloating 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