Allergy Progress Survey

Name ____ Date________________

COMPLAINTS:

Please circle the appropriate number 1-5 according to severity: 1 = mild, 5 = very severe, 0 = no problem

Nasal Discharge	0	1	2	3	4	5	Chronic Fatigue	0	1	2	3	4	5
Nasal Obstruction	0	1	2	3	4	5	Food Intolerance	0	1	2	3	4	5
Watery or itchy eyes	0	1	2	3	4	5	Frequent sinus or ear infection	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5	Frequent colds or sore throats	0	1	2	3	4	5
Wheezing	0	1	2	3	4	5	Learning disability	0	1	2	3	4	5
Cough	0	1	2	3	4	5	Poor memory or concentration	0	1	2	3	4	5
Itching	0	1	2	3	4	5	Hyperactivity	0	1	2	3	4	5
Eczema	0	1	2	3	4	5	Abdominal gas or cramping	0	1	2	3	4	5
Hives	0	1	2	3	4	5	Arthritis or muscle aching	0	1	2	3	4	5
Headache	0	1	2	3	4	5	Asthma	0	1	2	3	4	5

Other Symptoms____

Other Comments/Concerns about progress on the program so far:

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