Client Name _____ Date _____

Symptom Survey Questionnaire

Simply rate each of the following symptoms from zero to three. Add up your points, if you score 14 or more (or 10 or more in any one category) you are a great candidate for this program. Please be totally honest, this is your health! Enter one of the following number next to each symptom.

0 - Never or almost never have the symptom
1 - Occasionally has it, effect is not severe
2 - Frequently has it, effect is not severe
3 - Frequently has it, effect is severe

Digestive

	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Heartburn
	Belching, passing gas
	Total Score

Emotions

	Eyes
	Anxiety, fear, nervous
	Anger, irritability
	Depression
	Total Score

Eyes

	Watery, itchy eyes
	swollen, reddened, sticky eyelids
	dark circles under eyes
	Belching, passing gas
	Total Score

Lungs

	chest congestion
	Asthma, bronchitis
	Shortness of breath
	Difficulty breathing
	Total Score

Mind

	Poor memory
	Confusion
	Poor concentration
	Poor coordination
	Difficulty making decision
	Stutterling, stammering
	Slurred speech
	Learning disabilities
	Total Score

Energy/Activity

	Fatigue, sluggishness
	Apathy
	Hyperactivity
	Restlessness
	Total Score

Head

	Headache
	Faintness
	Dizziness
	Insomnia
	Total Score

Ears

	Headache
	Faintness
	Dizziness
	Insomnia
	Total Score

Mouth-Throat

	Chronic coughing
	Gagging, need to clear throat
	Sore throat, hoarse
	Swollen or discolored
	Total Score

Skin

	Acne
	Hives, rashes, dry skin
	Hair loss
	flushing, hot flashes
	Excessive sweating
	Total Score

Joints-Muscles

	Pain or aches in joints
	Arthritis
	Stiff, limited movement
	weakness or tiredness
	Pain, aches in muscles
	Total Score

Nose

	Stuffy nose
	Sinus problems
	Excessive mucus
	Hay fever, allergies
	Sneezing attacks
	Total Score

Heart

	Skipped heart beat
	Rapid heartbeats
	Chest pain
	Total Score

Weight

	Binge eating/drinking
	Craving certain foods
	Excessive weight gain
	Compulsive eating
	Water retention
	Underweight
	Total Score

Sleep

	Can't fall asleep
	difficulty staying asleep
	Always tired, even with adequate sleep
	Urinating at night
	Total Score

Other

	Frequent illness
	Frequent, urgent urination
	Genital itch, discharge
	Total Score

Add the numbers in each section, and then add the totals for each section to arrive at the grand total.

	GRAND TOTAL