FROM PAIN TO WELLNESS, LLC

MEDICAL SYMPTOMS QUESTIONNAIRE

NAME:________________________________ **DATE:**_______________________

Rate each of the following symptoms based on your typical health profile:

□ Past 30 days

Point Scale:

0-Never or almost never have the symptom
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

Section	Rating	Symptom	Total
HEAD	________	Headaches (G)	_______Total
	________	Faintness	
	________	Dizziness	
	________	Insomnia (MH)	
EYES	________	Watery or itchy eyes	_______Total
	________	Swollen, reddened or sticky eyelids	
	________	Bags or dark circles under eyes	
	________	Blurred or tunnel vision (does not Include near-or-far sightedness)	
EARS	________	Itchy Ears	_______Total
	________	Earaches, ear infections	
	________	Drainage from ears	
	________	Ringing in ears, hearing loss	
NOSE	________	Stuffy nose	_______Total
	________	Sinus problems	
	________	Hay fever	
	________	Sneezing attacks	
	________	Excessive mucus formation	
MOUTH/THROAT	________	Chronic coughing	_______Total
	________	Gagging, frequent need to clear throat	
	________	Sore throat, hoarseness, loss of voice	
	________	Swollen or discolored tongue, gums, lips (G)	
	________	Canker sores	
SKIN	________	Acne	_______Total
	________	Hives, rashes, dry skin (G)	
	________	Hair loss (MH)	
	________	Flushing, hot flashes (MH)	
	________	Excessive sweating (MH)	
HEART	________	Irregular or skipped heartbeat	_______Total
	________	Rapid or pounding heartbeat	
	________	Chest pain	
LUNGS	________	Chest congestion	_______Total
	________	Asthma, bronchitis	
	________	Shortness of breath	
	________	Difficulty breathing (G)	

Category	Score	Symptom	Total
DIGESTIVE TRACT	________	Nausea, vomiting	________ Total
	________	Diarrhea (G)	
	________	Constipation (G)	
	________	Bloated feeling (G)	
	________	Belching, passing gas (G)	
	________	Heartburn (G)	
	________	Intestinal/stomach pain (G)	
JOINT/MUSCLE	________	Pain or aches in joints (G)	________Total
	________	Arthritis (G)	
	________	Stiffness or limitation of movement (G)	
	________	Pain or aches in muscles (G)	
	________	Feeling of weakness or tiredness (G)	
WEIGHT	________	Binge eating/drinking	________Total
	________	Craving certain foods	
	________	Excessive weight (G)	
	________	Compulsive eating	
	________	Water retention	
	________	Underweight (G)	
ENERGY/ACTIVITY	________	Fatigue, sluggishness (G)	________ Total
	________	Apathy, lethargy	
	________	Hyperactivity	
	________	Restlessness	
MIND	________	Poor memory (MH)	________Total
	________	Confusion, poor comprehension (MH)	
	________	Poor concentration (MH)	
	________	Poor physical coordination	
	________	Difficulty in making decisions	
	________	Stuttering or stammering	
	________	Slurred speech	
	________	Learning disability	
EMOTIONS	________	Mood swings (MH)	________Total
	________	Anxiety, fear, nervousness	
	________	Anger, irritability, aggressiveness	
	________	Depression (MH)	
GENITOURINARY	________	Urinary Problems(Frequency, Incontinency,Retention)	
	________	Pre- Menopausal	________ Total
	________	Peri-Menopausal (Symptoms Starting)	
	________	Post- Menopausal	
	________	Sexual Dysfunction	
OTHER	________	Frequent illness	________ Total
	________	Frequent or urgent urination	
	________	Genital itch or discharge	

GRAND TOTAL ________

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