Symptom Checklist

Name: _____ Date: _____

Print out, complete, take to your healthcare professional

Frequency: 1- occasionally, 2- nearly every day, 3 most of the day, nearly every day

Severity- 1- mild 2- disrupts normal activities 3- Debilitating

How long: 1- one or 2 weeks 2- one to 3 months 3- One or more years

Symptom	Frequency (1-3)	Severity (1-3)	How Long (1-3)
Cognitive:			
Fatigue			
Anxiety, Fearfulness, Irritability			
Sleeping Difficulty			
Sleeping Excess			
Brain Fog, Slowed Thinking			
Anger, Aggressive Behavior			
Behavior or Personality Changes			
Mood Swings, Lability			
Apathy, Reduced Interests			
Hallucinations, Delusions			
Frequent Sadness, Crying			
Easily Distracted			
Memory Loss			
Changes in Appetite			

Unplanned Weight Changes			
Confusion			
Immune Process:			
Asthma, Cough, Breathing Trouble			
Frequent Yeast Infections			
Allergies			
Frequent Flu Symptoms			
Immunity Depressed, Frequent Illness			
Heart, Blood, Circulation:			
Blood Pressure High/Low			
High Cholesterol			
Heart Palpitation, Rhythm Abnormality			
Nervous System:			
Carpal Tunnell Syndrome			
Restless Leg Syndrome			
Numbness or Tingling Extremities			
Difficulty Walking, Poor Balance			
Spasm, Muscle Tics, Trembling			
Senses:			
Dizziness			
Vision Changes, Blurred Vision			
Light Sensitivity			
Tinnitus, Ringing, Ear Sounds			
Cold Sensitivity, Cold Extremities			
Excessive Sweating, Night Sweats			
GI System:			
Abdominal Pain			
Abdominal Swelling			
Colic			

Frequent Constipation or Diarrhea			
Excessive Thirst			
Indigestion, Heartburn, Gas			
Weight Gain			
Nausea			
Weight Loss or Poor Appetite			
Ulcers			
Frequent or Decreased Urination			
Reproductive System:			
Absence of Menstruation			
Irregular Periods			
Breast Pain, Tenderness			
Infertility			
Painful Intercourse, Dryness			
Hot Flashes			
Loss of Libido			
Erectile Dysfunction			
Pain:			
Migraines, Headaches			
Bone, Back or Leg Pain (skeletal)			
Joint Pain			
Muscle Pain			
Achiness			
Muscle Cramps			
Muscle Weakness			
Skin, Hair, Nails:			
Mouth Ulcers, Canker Sores			
Sores in Corners of Mouth			
Dry, Brittle Hair			
Hair Loss			
Dry or Itchy Skin			

Tender or Bleeding Gums			
Acne			
Eczema			
Pale Skin			
Skin Rash			
Edema, Swelling			
Please List Any Additional Symptoms:			
Diagnoses received in past 2 years (include chronic conditions):			
List all medications used in last 2 years			
List dosage size (mg), frequency, how long taken (months)			
How did the medication affect you? (good and bad)			
List all supplements used in last 2 years			
List dosage size (mg), frequency, how long taken (months)			

How did the supplements affect you? (good and bad)			
Family: List illnesses experienced by family members in last 2 years, or if deceased, in last 2 years of life			