Follow-up Symptom Survey

Date:	Patient Name:	Dietitian:

INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST WEEK**. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in box in front of the corresponding field for EVERY symptom listed. Also note the number of missed work days in the last week due to illness.

SCALE OF SYMPTOM POINTS
IF you did not suffer from the symptom ever or almost never, leave it blank.
1 = **OCCASIONALLY** (less than 2 times per week), and symptom **was MILD**
2 = **FREQUENTLY** (2 or more times per week), and symptom **was MILD**
3 = **OCCASIONALLY** (less than 2 times per week), and symptom **was SEVERE**
4 = **FREQUENTLY** (2 or more times per week), and symptom **was SEVERE**

Grand Total:	**# Missed Work Days**

	CONSTITUTIONAL
	Fatigue (sluggish, tired)
	Hyperactive (nervous energy)
	Restless (can't relax/sit still)
	Daytime sleepiness
	Insomnia at night
	Malaise (feeling lousy)
	Seizures
	TOTAL (0-28)
	EMOTIONAL/MENTAL
	Depression
	Anxiety (fears, uneasiness)
	Mood swings (rapid changes)
	Irritability
	Forgetfulness
	Lack of concentration/Brain fog
	Low sex drive
	TOTAL (0-28)
	HEAD/EARS
	Headache (not migraine)
	Migraine
	Earache
	Ear infection
	Ringing in ears
	Itchy ears
	Discharge from ears
	Sensitivity to sound
	TOTAL (0-32)
	SKIN
	Blemishes, acne
	Rashes or hives
	Eczema or psoriasis
	"Rosy" cheeks
	Flushing
	Itchy skin
	TOTAL (0-24)

	NASAL/SINUS
	Post nasal drip
	Sinus pain
	Runny nose
	Stuffy nose
	Sneezing
	TOTAL (0-20)
	MOUTH/THROAT
	Sore throat
	Swollen throat
	Swelling/burning lips/tongue
	Gagging/throat clearing
	Canker sores
	Difficulty swallowing
	TOTAL (0-24)
	LUNGS
	Wheezing
	Chest congestion
	Dry cough
	Wet cough
	Shortness of breath
	TOTAL (0-20)
	EYES
	Red or swollen eyes
	Watery eyes
	Itchy eyes
	Dark circles or "bags"
	Sensitivity to light
	Aura
	TOTAL (0-24)
	GENITOURINARY
	Increased urinary frequency
	Painful urination
	Bladder pain
	Bedwetting
	TOTAL (0-16)

	MUSCULOSKELETAL
	Joint pains
	Stiff joints
	Muscle aches
	Stiff muscles
	Ticks (facial or otherwise)
	Muscle spasms
	Muscle cramps
	TOTAL (0-28)
	CARDIOVASCULAR
	Irregular heartbeat
	High blood pressure
	TOTAL (0-8)
	DIGESTIVE
	Heartburn/reflux
	Stomach pains/cramps
	Intestinal pains/cramps
	Constipation
	Diarrhea
	Bloating sensation
	Gas (of any kind)
	Nausea
	Vomiting
	Painful elimination
	TOTAL (0-40)
	WEIGHT MANAGEMENT
	Current weight:
	Fluctuating weight
	Food cravings
	Water retention
	Binge eating or drinking
	Purging (all methods)
	TOTAL (0-20)
	LIST OTHER SYMPTOMS: