**Medical Symptom Questionnaire**

This Medical Symptom Questionnaire identifies symptoms that help to detect the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first visit, then record your symptoms for the last 48 hours ONLY.

POINT SCALE 🡪 mark an ‘X’ in the appropriate box

0 = I do not have this symptom 3 = Frequently have it, effect is not severe

1 = Occasionally have it, effect is not severe 4 = Frequently have it, effect is severe

2 = Occasionally have it, effect is severe

**MEDICAL SYMPTOMS:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DIGESTIVE TRACT** | **0** | **1** | **2** | **3** | **4** | **LUNGS** | **0** | **1** | **2** | **3** | **4** |
| Nausea or vomiting |  |  |  |  |  | Chest congestion |  |  |  |  |  |
| Diarrhea |  |  |  |  |  | Asthma, bronchitis |  |  |  |  |  |
| Constipation |  |  |  |  |  | Shortness of breath |  |  |  |  |  |
| Bloated feeling |  |  |  |  |  | Difficult breathing |  |  |  |  |  |
| Belching or passing gas |  |  |  |  |  | **Lungs Total** |  |
| Heartburn |  |  |  |  |  | **MIND** | **0** | **1** | **2** | **3** | **4** |
| Intestinal/Stomach pain |  |  |  |  |  | Poor memory |  |  |  |  |  |
| **Digestive Tract Total** |  | Confusion, poor comprehension |  |  |  |  |  |
| **EARS** | **0** | **1** | **2** | **3** | **4** | Poor concentration |  |  |  |  |  |
| Itchy ears |  |  |  |  |  | Poor physical coordination |  |  |  |  |  |
| Earaches, ear infections |  |  |  |  |  | Difficulty in making decisions |  |  |  |  |  |
| Drainage from ear |  |  |  |  |  | Stuttering or stammering |  |  |  |  |  |
| Ringing in ear, hearing loss |  |  |  |  |  | Slurred speech |  |  |  |  |  |
| **Ears Total** |  | Learning disabilities |  |  |  |  |  |
| **EMOTIONS** | **0** | **1** | **2** | **3** | **4** | **Mind Total** |  |
| Mood swings |  |  |  |  |  | **MOUTH/THROAT** | **0** | **1** | **2** | **3** | **4** |
| Anxiety, fear, or nervousness |  |  |  |  |  | Chronic coughing |  |  |  |  |  |
| Anger, irritability, aggressiveness |  |  |  |  |  | Gagging, frequent need to clear throat |  |  |  |  |  |
| Depression |  |  |  |  |  | Sore throat, hoarseness, loss of voice |  |  |  |  |  |
| **Emotions Total** |  | Swollen/discolored tongue, gum, lips |  |  |  |  |  |
| **ENERGY/ACTIVITY** | **0** | **1** | **2** | **3** | **4** | Canker sores |  |  |  |  |  |
| Fatigue, sluggishness |  |  |  |  |  | **Mouth/Throat Total** |  |
| Apathy, lethargy |  |  |  |  |  | **NOSE** | **0** | **1** | **2** | **3** | **4** |
| Hyperactivity |  |  |  |  |  | Stuffy nose |  |  |  |  |  |
| Restlessness |  |  |  |  |  | Sinus problems |  |  |  |  |  |
| **Energy/Activity Total** |  | Hay fever |  |  |  |  |  |
| **EYES** | **0** | **1** | **2** | **3** | **4** | Sneezing attacks |  |  |  |  |  |
| Watery or itchy eyes |  |  |  |  |  | Excessive mucus formation |  |  |  |  |  |
| Swollen, reddened or sticky eyelids |  |  |  |  |  | **Nose Total** |  |
| Bags or dark circles under eyes |  |  |  |  |  |  (continued on next page) |
| Blurred or tunnel vision (does not include near or far-sightedness) |  |  |  |  |  |
| **Eyes Total** |  |
| **HEAD** | **0** | **1** | **2** | **3** | **4** | **SKIN** | **0** | **1** | **2** | **3** | **4** |
| Headaches |  |  |  |  |  | Acne |  |  |  |  |  |
| Faintness |  |  |  |  |  | Hives, rashes or dry skin |  |  |  |  |  |
| Dizziness |  |  |  |  |  | Hair loss |  |  |  |  |  |
| Insomnia |  |  |  |  |  | Flushing or hot flashes |  |  |  |  |  |
| **Head Total** |  | Excessive sweating |  |  |  |  |  |
| **HEART** | **0** | **1** | **2** | **3** | **4** | **Skin Total** |  |
| Irregular or skipped heartbeat |  |  |  |  |  | **WEIGHT** | **0** | **1** | **2** | **3** | **4** |
| Rapid or pounding heartbeat |  |  |  |  |  | Binge eating/drinking |  |  |  |  |  |
| Chest pain |  |  |  |  |  | Craving certain foods |  |  |  |  |  |
| **Heart Total** |  | Excessive weight |  |  |  |  |  |
| **JOINTS/MUSCLES** | **0** | **1** | **2** | **3** | **4** | Compulsive eating |  |  |  |  |  |
| Pain or aches in joints |  |  |  |  |  | Water retention |  |  |  |  |  |
| Arthritis |  |  |  |  |  | Underweight |  |  |  |  |  |
| Stiffness or limitation of movement |  |  |  |  |  | **Weight Total** |  |
| Pain or aches in muscles |  |  |  |  |  | **OTHER** | **0** | **1** | **2** | **3** | **4** |
| Feeling of weakness or tiredness |  |  |  |  |  | Frequent illness |  |  |  |  |  |
| **Joints/Muscles Total** |  | Frequent or urgent urination |  |  |  |  |  |
| *KEY TO QUESTIONNAIRE:*Grand Total - Optimal: <10, Mild Toxicity: 10-50, Moderate Toxicity: 50-100, Severe Toxicity: > 100 | Genital itch or discharge |  |  |  |  |  |
| **Other Total** |  |
|  |
| **GRAND TOTAL** |  |

Environmental exposures (i.e. mold, metal fillings, pesticides, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Traumatic experiences (i.e. surgery, accident, abuse, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis/Diagnoses given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies/Intolerances \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet. I eat… Whatever I want Paleo. Keto. Vegetarian. Vegan. Mediterranean. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: Instagram Facebook LinkedIn IFM Word of Mouth (If so who \_\_\_\_\_\_\_\_\_\_\_\_\_). Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize my health information to be released to:

Signature: Date:

CONTACT INFO

Patient Name: Date of Birth:

Street Address: City, Zip:

Email: Phone #:

**GOALS:** 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_