THE·HEALTHOLOGY·COMPANY
RESTORING YOUR HEALTH

Symptom Checklist

Name: _____

Please mark only one column per office visit.

Visit #, Date ➡								
SYMPTOMS								
Neurological	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Trouble getting to sleep								
Trouble staying asleep								
Difficulty waking up								
Trouble staying awake								
Tired most of the time								
Weakness								
Lack of endurance								
Depression								
Loss of pleasure / interest								
Crying spells								
Agitation								
Excess worry								
Phobias / Fearful								
Panic attacks								
Anxious or nervous								
Suspicious								
Irritability / Anger								
Delusions								
Hallucinations								
Seizures								
Tremor								
Shaky feeling								
Hyperactive								
Balance problems								
Feel faint								
Blackouts								
Dizziness / Light headed								
Spinning								
With position change								
Difficulty concentrating								
Trouble thinking clearly								
Indecisive								
Confusion								
Memory disturbance								
Learning disability								
Difficulty with speech								
Difficulty with writing								
Taste diminished or gone								
Decreased sense of smell								
Vision blurred								
Trouble focusing								
Loss of hearing								
Ears ringing								
Frequently too hot								
Frequently too cold								
Headaches - Migraine type								
Stress type								
Sinus type								
Numbness								
TOTAL								

Instructions:

Rate each symtom on each visit using the following scale.
Please complete only one column per visit.

(Blank) - No trouble
1 - Mildly Troublesome
2 - Moderately Troublesome
3 - Severly Troublesome

Please total each section where indicated.

Gastrointestinal	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Mouth ulcers--cancers								
Mouth / tongue raw or sore								
Heartburn								
Indigestion								
Excess acidity								
Gastritis or "acid stomach"								
Gastric ulcers								
Nausea								
Abdominal pain								
Sore all over								
Cramping pain								
Upper abdominal pain								
Lower abdominal pain								
Gas pains								
Intestinal gas								
Abdominal bloating								
Constipation								
Diarrhea								
Alternating constipation/diarrhea								
Rectal itch								
Food cravings								
Fluctuating appetite								
Loss of appetite								
Excessive hunger								
TOTAL								

Cardiovasular	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Chest pain								
Chest pain only w/ exertion								
Leg pain on exertion								
Swelling of feet, legs, hands								
Cold hands and feet								
Rapid pulse/pounding heart for no apparent reason								
TOTAL								

Musculoskeletal	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Aching generalized								
Muscle soreness								
Muscle cramps								
Muscle weakness								
Muscle jerks								
Muscle stiffness								
Arthritis, join pain								
Back pain								
Stiffness in neck and shoulders								
TOTAL								