Health Profile

Name: ______________________________________ **Date:** _________________

Rate each of the following symptoms based upon your typical health profile for: *Past 30 Days* *Past 48 Hours*

Point Scale	
	0 *Never* or *almost never* have the symptom
	1 *Occasionally* have symptom, effect is *not severe*
	2 *Occasionally* have symptom, effect is *severe*
	3 *Frequently* have symptom, effect is *not severe*
	4 *Frequently* have symptom, effect is *severe*

Head	____ Headaches ____ Faintness ____ Dizziness ____ Insomnia ____ **TOTAL**	**Digestive Tract**	____ Nausea, vomiting ____ Diarrhea ____ Constipation ____ Bloated feeling ____ Belching, gas ____ Heartburn ____ Intestinal or stomach pain ____ **TOTAL**
Eyes	____ Watery or itchy eyes ____ Swollen, reddened or sticky eyelids ____ Bags or dark circles under eyes ____ Blurred or tunnel vision (not near- or far-sightedness) ____ **TOTAL**	**Joints/ Muscles**	____ Pain or aches in joints ____ Arthritis ____ Stiffness or limitation of movement ____ Pain or aches in muscles ____ Feeling of weakness or tiredness ____ **TOTAL**
Ears	____ Itchy ears ____ Earaches, ear infections ____ Drainage from ear ____ Ringing in ears, hearing loss ____ **TOTAL**	**Weight**	____ Binge eating/drinking ____ Craving certain foods ____ Excessive weight ____ Compulsive eating ____ Water retention ____ Underweight ____ **TOTAL**
Nose	____ Stuffy nose, excessive mucus formation ____ Sinus problems ____ Hay fever ____ Sneezing attacks ____ **TOTAL**	**Energy/ Activity**	____ Fatigue ____ Apathy, lethargy ____ Hyperactivity ____ Restlessness ____ **TOTAL**
Mouth/ Throat	____ Chronic coughing ____ Gagging, frequent need to clear throat ____ Sore throat, hoarseness, loss of voice ____ Swollen or discolored tongue, gums or lips ____ Canker sores ____ **TOTAL**	**Mind**	____ Poor memory ____ Confusion ____ Poor focus ____ Poor coordination ____ Difficulty making decisions ____ Stuttering or stammering ____ Slurred speech ____ Learning disabilities ____ **TOTAL**
Skin	____ Acne ____ Hives, rashes, dry skin ____ Hair loss ____ Flushing, hot flashes, excessive sweating ____ **TOTAL**	**Emotions**	____ Mood swings ____ Anxiety, fear, nervousness ____ Anger, irritability, aggressiveness ____ Depression ____ **TOTAL**
Heart	____ Irregular or skipped heartbeat ____ Rapid or pounding heartbeat ____ Chest pain ____ **TOTAL**	**Other**	____ Frequent illness ____ Frequent or urgent urination ____ **TOTAL**
Lungs	____ Chest congestion ____ Asthma, bronchitis ____ Shortness of breath ____ Difficulty breathing ____ **TOTAL**	**GRAND TOTAL**	_______