Health Symptoms Questionnaire

Name: ______________________________ Date: ______________

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Category	Symptom					
Digestive tract	Nausea, vomiting	0	1	2	3	4
	Diarrhea	0	1	2	3	4
	Constipation	0	1	2	3	4
	Bloated feeling	0	1	2	3	4
	Heartburn	0	1	2	3	4
	Intestinal, stomach pain	0	1	2	3	4
	Digestive total:					
Joints/muscles	Pain or aches in joints	0	1	2	3	4
	Arthritis, joint swelling	0	1	2	3	4
	Stiff or limitation of movement	0	1	2	3	4
	Pain or aches in muscles	0	1	2	3	4
	Feeling of weakness or tired	0	1	2	3	4
	Joints/muscles total:					
Emotional	Mood swings	0	1	2	3	4
	Anxiety, fear, nervousness	0	1	2	3	4
	Anger, irritability, aggression	0	1	2	3	4
	Depression	0	1	2	3	4
	Emotional total:					
Weight/food	Binge eating, drinking	0	1	2	3	4
	Craving certain foods	0	1	2	3	4
	Excessive weight	0	1	2	3	4
	Compulsive eating, food addictions	0	1	2	3	4
	Water retention	0	1	2	3	4
	Underweight	0	1	2	3	4
	Weight/food total:					
Energy/sleep	Fatigue, sluggishness	0	1	2	3	4
	Apathy, lethargy	0	1	2	3	4
	Hyperactivity	0	1	2	3	4
	Restlessness, achiness	0	1	2	3	4
	Sleep disturbances	0	1	2	3	4
	Energy/sleep total:					
Skin	Acne	0	1	2	3	4
	Hives, rashes, dry skin, redness	0	1	2	3	4
	Hair loss	0	1	2	3	4
	Flushing, hot flashes	0	1	2	3	4
	Excessive sweating	0	1	2	3	4
	Skin total:					
Heart	Irregular or skipped heartbeat	0	1	2	3	4
	Rapid or pounding heartbeat	0	1	2	3	4
	Chest pain	0	1	2	3	4
	Heart total:					
Other	Frequent illness	0	1	2	3	4
	Frequent or urgent urination	0	1	2	3	4
	Genital itch or discharge	0	1	2	3	4
	Other total:					
Respiratory	Chest congestion	0	1	2	3	4
	Asthma, bronchitis	0	1	2	3	4
	Shortness of breath	0	1	2	3	4
	Difficulty breathing	0	1	2	3	4
	Respiratory total:					
Eyes	Watery or itchy eyes	0	1	2	3	4
	Swollen, red, or sticky eyelids	0	1	2	3	4
	Bags or dark circles under eyes	0	1	2	3	4
	Blurred or restricted vision	0	1	2	3	4
	Eyes total:					
Nose	Stuffy nose	0	1	2	3	4
	Sinus problems or dripping nose	0	1	2	3	4
	Hay fever	0	1	2	3	4
	Sneezing attacks	0	1	2	3	4
	Excessive mucus	0	1	2	3	4
	Nose total:					
Mouth/throat	Frequent, consistent coughing	0	1	2	3	4
	Gagging, need to clear throat	0	1	2	3	4
	Sore throat, hoarse, loss of voice	0	1	2	3	4
	Swollen or discolored tongue, gums, or lips	0	1	2	3	4
	Canker sores, other mouth sores	0	1	2	3	4
	Mouth/throat total:					
Ears	Itchy ears	0	1	2	3	4
	Earaches, ear infections	0	1	2	3	4
	Drainage from ear, waxy buildup	0	1	2	3	4
	Ringing in ears, hearing loss	0	1	2	3	4
	Ears total:					
Head	Headaches	0	1	2	3	4
	Faintness or lightheadedness	0	1	2	3	4
	Dizziness	0	1	2	3	4
	Head total:					
Cognitive	Poor memory, recall	0	1	2	3	4
	Confusion, poor comprehension	0	1	2	3	4
	Poor concentration	0	1	2	3	4
	Poor physical coordination	0	1	2	3	4
	Difficulty making decisions	0	1	2	3	4
	Stuttering, stammering	0	1	2	3	4
	Slurred speech	0	1	2	3	4
	Learning disabilities	0	1	2	3	4
	Cognitive total:					

Grand total __________

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