Back to Health Wellness Center- Jacob Bastomski D.C..D.I.B.C.N. 1900 State Street. Suite H (805) 569-5000

Brief Symptom Survey Questionnaire

On a scale of 0 – 10, with 0 being no problem at all and 10 being a very severe problem, please rate the following: (circle the items which are applicable.)

Minimal Problem — Medium Problem — Severe Problem

STRESS There is lots of stress in my life which affects me
0 1 2 3 4 5 6 7 8 9 10

MOOD Depression, Anxiety, Irritability
0 1 2 3 4 5 6 7 8 9 10

FATIGUE Lack of energy, Afternoon fatigue
0 1 2 3 4 5 6 7 8 9 10

DIGESTION Bloating, Heartburn, Abdominal pain, Constipation, Diarrhea
0 1 2 3 4 5 6 7 8 9 10

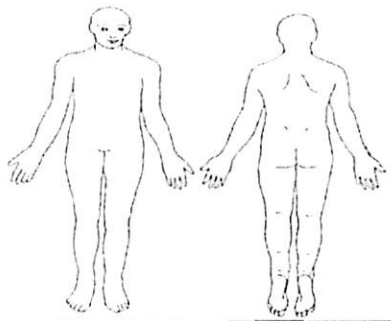
SLEEP Difficult to fall asleep and/or difficult to sleep through the night.
0 1 2 3 4 5 6 7 8 9 10

I sleep a total of ____ hours per night. I wake up approximately ___ times per night.

I wake up feeling tired and not ready to start the day.
0 1 2 3 4 5 6 7 8 9 10

PAIN Overall my pain level is
0 1 2 3 4 5 6 7 8 9 10

Please mark pain area(s)



BLOOD SUGAR

I crave sweets
0 1 2 3 4 5 6 7 8 9 10

I crave sweets after a meal
0 1 2 3 4 5 6 7 8 9 10

I get sleepy after a meal
0 1 2 3 4 5 6 7 8 9 10

I get irritable, anxious, dizzy, if I go too long without eating
0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____ Today's Date: _____