Health Profile Questionnaire

NAME________________________ DATE ____________ WEEK__________

POINT SCALE
- 0 Never or almost never 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

Rate each of the following symptoms based upon your typical health profile using the point scale on the left.

HEAD
- ______ Headaches
- ______ Faintness
- ______ Dizziness
- ______ Insomnia
- ______ **TOTAL**

EYES
- ______ Watery or itchy eyes
- ______ Swollen, reddened, or sticky eyelids
- ______ Bags or dark circles under eyes
- ______ Blurred or tunnel vision (does not include near or far-sightedness)
- ______ **TOTAL**

EARS
- ______ Itchy ears
- ______ Ear aches, ear infections
- ______ Drainage from ear
- ______ Ringing in ears, hearing loss
- ______ **TOTAL**

NOSE
- ______ Stuffy nose
- ______ Sinus problems
- ______ Hay fever
- ______ Sneezing attacks
- ______ Excessive mucus formation
- ______ **TOTAL**

MOUTH / THROAT
- ______ Chronic coughing
- ______ Gagging, frequent need to clear throat
- ______ Sore throat, hoarseness, loss of voice
- ______ Snoring
- ______ Wheezing
- ______ Canker sores
- ______ **TOTAL**

SKIN
- ______ Acne
- ______ Hives, rashes, dry skin
- ______ Hair loss
- ______ Flushing, hot flashes
- ______ Excessive sweating
- ______ **TOTAL**

HEART
- ______ Irregular or skipped heartbeat
- ______ Rapid or pounding heartbeat
- ______ Chest pain
- ______ **TOTAL**

LUNGS
- ______ Chest congestion
- ______ Asthma, bronchitis
- ______ Shortness of breath
- ______ Difficulty breathing
- ______ **TOTAL**

DIGESTIVE TRACT
- ______ Nausea, vomiting
- ______ Diarrhea
- ______ Constipation
- ______ Bloated feeling
- ______ Belching, passing gas
- ______ Heartburn
- ______ Intestinal/stomach pain
- ______ **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**

WEIGHT
- ______ Binge eating/drinking
- ______ Craving certain foods
- ______ Excessive weight
- ______ Compulsive eating
- ______ Water retention
- ______ Underweight
- ______ **TOTAL**

ENERGY / ACTIVITY
- ______ Fatigue, sluggishness
- ______ Apathy, lethargy
- ______ Hyperactivity
- ______ Restlessness
- ______ **TOTAL**

MIND
- ______ Poor memory
- ______ Confusion, poor comprehension
- ______ Poor concentration
- ______ Poor physical coordination
- ______ Difficulty in making decisions
- ______ Stuttering or stammering
- ______ Slurred speech
- ______ Learning disabilities
- ______ **TOTAL**

EMOTIONS
- ______ Mood swings
- ______ Anxiety, fear, nervousness
- ______ Anger, irritability, aggressiveness
- ______ Depression
- ______ **TOTAL**

OTHER
- ______ Frequent illness
- ______ Frequent or urgent urination
- ______ Genital itch or discharge
- ______ **TOTAL**

Fill out every few weeks to track your progress.

______ **GRAND TOTAL**