HEALTH PROFILE QUESTIONAIRE

Name: ______________________________ **Date:** ______________

Rate each of the following symptoms based on your typical health profile for the past month.

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*

Category	Score	Symptom
HEAD	______	Headaches
	______	Faintness
	______	Dizziness
	______	Insomnia **TOTAL** ______
EYES	______	Watery, dry, or itchy eyes
	______	Swollen, reddened or sticky eyelids
	______	Bags or dark circles under eyes
	______	Blurred or tunnel vision **TOTAL** ______
EARS	______	Itchy ears
	______	Earaches, ear infections
	______	Drainage from ear
	______	Ringing in ears, hearing loss **TOTAL** ______
NOSE	______	Stuffy nose
	______	Sinus problems
	______	Hay fever/Seasonal Allergies
	______	Sneezing attacks
	______	Excessive mucus formation **TOTAL** ______
MOUTH/ THROAT	______	Chronic coughing
	______	Gagging, frequent need to clear throat
	______	Sore throat, hoarseness, loss of voice
	______	Swollen or discolored tongue, gums, lips
	______	Mouth sores, ulcers
	______	Excessive mucus formation **TOTAL** ______
SKIN, HAIR, and NAILS	______	Acne
	______	Hives, rashes, dry skin, eczema, psoriasis
	______	Hair loss or changes
	______	Flushing, hot flashes
	______	Thin, peeling nails
	______	Ridges/Spots on nails
	______	Excessive sweating **TOTAL** ______
HEART	______	Chest pain or tightness
	______	Irregular or skipped heartbeat
	______	Rapid or pounding heartbeat **TOTAL** ______
LUNGS	______	Chest congestion
	______	Asthma, bronchitis
	______	Shortness of breath
	______	Difficulty breathing **TOTAL** ______

Category	Score	Symptom
DIGESTIVE TRACT	______	Nausea, vomiting
	______	Diarrhea, Irritable Bowel
	______	Constipation
	______	Bloated feeling
	______	Belching, passing gas
	______	Heartburn/Reflux
	______	Intestinal/Stomach pain **TOTAL** ______
JOINTS/ MUSCLE	______	Pain or aches in joints
	______	Arthritis
	______	Stiffness or limitation of movement
	______	Feeling of weakness or tiredness
	______	Pain or aches in muscles **TOTAL** ______
WEIGHT	______	Emotional or Binge eating/drinking
	______	Craving certain foods
	______	Excessive weight
	______	Water retention
	______	Underweight **TOTAL** ______
ENERGY/ ACTIVITY	______	Fatigue, sluggishness, frequent illness
	______	Apathy, lethargy
	______	Interrupted Sleep/Insomnia
	______	Hyperactivity
	______	Restlessness **TOTAL** ______
MIND	______	Poor memory
	______	Confusion, poor comprehension
	______	Difficulty in making decisions
	______	Stuttering or stammering
	______	Difficulty with focus or concentration
	______	Poor physical coordination **TOTAL** ______
EMOTIONS	______	Mood swings
	______	Anxiety, fear, nervousness
	______	Anger, irritability, aggressiveness
	______	Panic
	______	Depression **TOTAL** ______
GENDER	______	PMS
	______	Disinterest in Sex
	______	Vaginal Dryness/Erectile Dysfunction
	______	Frequent or urgent urination
	______	Genital itch or discharge **TOTAL** ______
		GRAND TOTAL: ____________

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