LifeSource
HEALTH PARTNERS

Wellness Elevated *Living Transformed*

Symptom Checklist

Please place a checkmark at each of your symptoms. Be sure to include symptoms that you've learned to live with.

Digestive Tract
- ❑ Belching
- ❑ Bloated feeling
- ❑ Constipation
- ❑ Diarhea\Nausea
- ❑ Passing gas
- ❑ Stomach pains
- ❑ Vomiting

Ears
- ❑ Drainage form ear
- ❑ Ear aches
- ❑ Ear infections
- ❑ Hearing loss
- ❑ Itchy ears
- ❑ Ringing in ears

Emotions
- ❑ Aggressiveness
- ❑ Anxiety/fear
- ❑ Depression
- ❑ Irritability/anger
- ❑ Mood swings
- ❑ Nervousness

Energy & Activity
- ❑ Apathy
- ❑ Fatigue
- ❑ Hyperactivity
- ❑ Lethargy
- ❑ Restlessness
- ❑ Sluggishness

Eyes
- ❑ Blurred vision
- ❑ Dark circles
- ❑ Itchy eyes
- ❑ Sticky eyerlids
- ❑ Swollen eyelids
- ❑ Watery eyes

Head
- ❑ Dizziness
- ❑ Faintness
- ❑ Headaches
- ❑ Insominia
- ❑ Lightheadedness

Joint & Muscles
- ❑ Aches in mucles
- ❑ Arthritis
- ❑ Feeling of weakness
- ❑ Limited movement
- ❑ Pain in joints
- ❑ Stiffness

Lungs
- ❑ Asthma/bronchitis
- ❑ Chest congestion
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Wheezing

Mind
- ❑ Confusion
- ❑ Learning disabilites
- ❑ Poor concentration
- ❑ Poor memory
- ❑ Stuttering/stammering

Mouth & Throat
- ❑ Canker sores
- ❑ Chroic coughing
- ❑ Gagging
- ❑ Often clear throat
- ❑ Sore throat
- ❑ Swollen tongue/lips/gums

Nose
- ❑ Excessive mucous
- ❑ Hay fever
- ❑ Sinus problems
- ❑ Sneezing attacks
- ❑ Stuffy nose

Skin
- ❑ Acne
- ❑ Dermatitis
- ❑ Eczema
- ❑ Excessive sweating
- ❑ Flushing/hot flashes
- ❑ Hair loss
- ❑ Hives/rashes
- ❑ Itching

Weight
- ❑ Binge eating
- ❑ Compulsive eating
- ❑ Cravings
- ❑ Excessive weight
- ❑ Underweight
- ❑ Water retention

Other
- ❑ Anaphylactic reactions
- ❑ Chest pains
- ❑ Frequent illness
- ❑ Genital itch
- ❑ Irregular heartbeat
- ❑ Rapid heartbeat
- ❑ Urgent urination

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Symptom Checklist

During the last 30 days, have the symptoms you noted on the previous page. . .

1. Prevented you from getting a good night's sleep? ❑ **Yes** ❑ **No**

If yes, which symptoms? ______________________ How many nights?__________

2. Affected your performance at your place of employment? ❑ **Yes** ❑ **No**

If yes, which symptoms? ______________________ How many nights?__________

3. Caused you to call in sick toyour place of employment? ❑ **Yes** ❑ **No**

If yes, which symptoms? ______________________ How many nights?__________

4. Caused you to leave your place of employment early? ❑ **Yes** ❑ **No**

If yes, which symptoms? ______________________ How many nights?__________

Do you or anyone in your family have a history or allergies? ❑ **Yes** ❑ **No**

Have you or has anyone in your family ever been to an allergist or been tested for allergies?
❑ **Yes** ❑ **No**

Do you have allergic reactions within 15 minutes or sooner arfrter exposure to particular topical, ingeted or inhaled substances such as:

- ❑ Animal danders
- ❑ Cosmetics
- ❑ Dust, pollen and mold
- ❑ Foods
- ❑ Insect stings
- ❑ Iodine
- ❑ Latex
- ❑ Laundry
- ❑ Medicines
- ❑ Penicillin
- ❑ Plants
- ❑ Shampoos and soaps
- ❑ Skin cream
- ❑ Sulfur

If so, can you indentify the particualr offending substance?

____

Do you have severe, dramatic allergic reactions (ananphulaxis) with skin reactions, swelling, respiratory distress, and/or low blood pressure?

____

If so, what causes it? (eg., bee stings, penicillian, etc.)

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