MEDICAL SYMPTOM QUESTIONNAIRE

Please complete form in pen.

BASED ON THE PAST 30 DAYS rate each of the following symptoms based upon your typical health profile. If you are dealing with more than one symptom listed below then please circle all that apply.

NAME ______________________________ DATE ______________________

Please use the scale shown below to describe the severity of your symptom (please total each section)

- **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***

HEAD
- ______ Headaches
- ______ Dizziness/Faintness
- ______ Insomnia
- ______ **TOTAL (this section)**

EYES
- ______ Watery or itchy eyes
- ______ Swollen, reddened or sticky eyelids
- ______ Dark circles under eyes
- ______ Vision problems (excluding near or farsighted)
- ______ **TOTAL (this section)**

EARS
- ______ Itchy ears
- ______ Frequent ear infections
- ______ Popping of ears
- ______ Ringing in ears
- ______ **TOTAL (this section)**

NOSE
- ______ Stuffy nose/Excessive mucus formation
- ______ Sinus problems
- ______ Hay fever/Sneezing attacks
- ______ Nose bleeding
- ______ **TOTAL (this section)**

MOUTH/
- ______ Gagging, frequent need to clear throat
- ______ Sore throat, hoarseness, loss of voice
- ______ Swollen/Discolored tongue, gums, lips
- ______ Canker sores
- ______ **TOTAL (this section)**

SKIN
- ______ Acne
- ______ Hives, rashes, dry skin
- ______ Hair loss
- ______ Excessive hair growth
- ______ Excessive sweating/Body odor
- ______ Flushing, hot flashes
- ______ **TOTAL (this section)**

HEART
- ______ Irregular or skipped heartbeat
- ______ Rapid or pounding heartbeat
- ______ Chest pain
- ______ **TOTAL (this section)**

LUNGS
- ______ Chest congestion
- ______ Asthma, frequent bronchitis
- ______ Difficulty breathing
- ______ Frequent coughing
- ______ **TOTAL (this section)**

DIGESTIVE TRACT
- ______ Nausea, vomiting
- ______ Diarrhea, loose stools
- ______ Constipation, hard/infrequent stools
- ______ Bloated feeling
- ______ Belching, passing gas, burping
- ______ Heartburn/acid taste in mouth
- ______ Intestinal/stomach pain
- ______ **TOTAL (this section)**

JOINTS / MUSCLE
- ______ Pain or aches in joints/Arthritis
- ______ Warm, swollen joints
- ______ Stiffness or limitation of movement
- ______ Pain or aches in muscles
- ______ Muscle weakness
- ______ **TOTAL (this section)**

WEIGHT
- ______ Excessive eating/drinking
- ______ Strong/Excessive craving certain foods
- ______ Overweight/Obese
- ______ Difficulty losing weight
- ______ Water retention
- ______ Difficulty gaining weight
- ______ **TOTAL (this section)**

ENERGY / ACTIVITY
- ______ Fatigue from physical exhaustion
- ______ Fatigue from emotional exhaustion
- ______ Hyperactivity (mind or body)
- ______ Restlessness (mind or body)
- ______ **TOTAL (this section)**

MIND
- ______ Poor memory
- ______ Confusion, poor comprehension
- ______ Poor concentration
- ______ Poor physical coordination
- ______ Difficulty making decisions
- ______ Speech difficulty
- ______ Learning disabilities
- ______ **TOTAL (this section)**

EMOTIONS
- ______ Mood swings
- ______ Anxiety, fear, nervousness
- ______ Anger, irritability, aggressiveness
- ______ Depression/Sadness
- ______ Obsessive, compulsive behaviors
- ______ **TOTAL (this section)**

OTHER
- ______ Frequent illness
- ______ Frequent or urgent urination
- ______ Genital itch or discharge
- ______ **TOTAL (this section)**

SUM OF ALL SECTIONS ABOVE: ______

HEALTH GOALS

Name:___________________________________ Date: __________________

*Please describe the **top three (3) HEALTH GOALS** you seek to address in the coming year **(<u>in order of importance</u>)**.*

GOAL #1:

GOAL #2:

GOAL #3:

SMOKING/TOBACCO

Currently smoking? ○ Yes ○ No

Previous smoking? ○ Yes ○ No

Quit Date: ____________

Smokeless tobacco? ○ Yes ○ No

If yes, do you use: ○ Chew ○ Vape

ALCOHOL INTAKE

How many drinks currently per week? *(1 drink = 5oz wine, 12 oz beer, 1.5 oz liquor)*

○ None ○ 1-3 ○ 4-6 ○ 7-10 ○ >10

Do you frequently (more than 2x/week) take:

○ >1 drink per day for females

○ >2 drinks per day for males

List any SURGERY or HOSPITALIZATION you have had in the past 12 months

Date	Reason for Hospitalization

SPECIALIST CARE *Please list ALL physicians you have seen in the past 12 months*

Physician Name	Medical Specialty	Issue(s) Being Managed

MEDICATION HISTORY

Attach separate page as needed

CURRENT MEDICATIONS

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Use?

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Stopping?

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement	Strength	Dosing Schedule	Start Date (month/year)	Brand of Supplement

ALLERGIES (ENVIRONMENTAL, FOOD & DRUGS)

Allergen	Associated Symptoms	Treatment needed, if applicable

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ DATE: ______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: ____________

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	________
	Somewhat difficult	________
	Very difficult	________
	Extremely difficult	________

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