TESTING SCALE

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

POINT SCALE:

0 – Never (0 days per month)
1 – Sometimes (1-5 days per month)
2 – Occasionally (5-7 days per month)
3 – Frequently (7-10 days per month)
4 – Often (10+ days per month)

DIGESTIVE TRACT

__ Nausea or vomiting — Total
__ Diarrhea
__ Constipation
__ Bloated feeling
__ Belching, or passing gas
__ Heartburn — _____

EARS

__ Itchy ears — Total
__ Earaches, ear infections
__ Drainage from ear
__ Ringing in ears, hearing loss — _____

EMOTIONS

__ Mood swings — Total
__ Anxiety, fear or nervousness
__ Anger, irritability, or aggressiveness
__ Depression — _____

ENERGY/ACTIVITY

__ Fatigue, sluggishness — Total
__ Apathy, lethargy
__ Hyperactivity
__ Restlessness — _____

EYES

__ Watery or itchy eyes — Total
__ Swollen, reddened or sticky eyelids
__ Bags or dark circles under eyes
__ Blurred or tunnel vision
(Does not include near or far-sightedness) — _____

HEAD

__ Headaches — Total
__ Faintness
__ Dizziness
__ Insomnia — _____

HEART

__ Irregular or skipped heartbeat — Total
__ Rapid or pounding heartbeat
__ Chest pain — _____

JOINTS/MUSCLES

__ Pain or aches in joints — Total
__ Arthritis
__ Stiffness or limitation of movement
__ Pain or aches in muscles
__ Feeling of weakness or tiredness — _____

LUNGS

__ Chest congestion — Total
__ Asthma, bronchitis
__ Shortness of breath
__ Difficulty breathing — _____

MIND

__ Poor memory — Total
__ Confusion, poor comprehension
__ Poor concentration
__ Poor physical coordination
__ Difficulty making decisions
__ Stuttering or stammering
__ Slurred speech
__ Learning disabilities — _____

MOUTH/THROAT

__ Chronic coughing — Total
__ Gagging, frequent need to clear throat
__ Sore Throat, hoarseness, loss of voice
__ Swollen or discolored tongue, gums, lips
__ Canker sores — _____

NOSE

__ Stuffy nose — Total
__ Sinus problems
__ Hay fever
__ Sneezing attacks
__ Excessive mucus formation — _____

SKIN

__ Acne — Total
__ Hives, rashes, or dry skin
__ Hair loss
__ Flushing or hot flashes
__ Excessive sweating — _____

WEIGHT

__ Binge eating/drinking — Total
__ Craving certain foods
__ Excessive weight
__ Compulsive eating
__ Water retention
__ Underweight — _____

OTHER

__ Frequent illness — Total
__ Frequent or urgent urination
__ Genital itch or discharge — _____

GRAND TOTAL _____