Patient Questionnaire

Patient Name:_____ **Date of Exam:** _____

Date of Birth:____/_____/_____

SCALE OF SYMPTOM POINTS:	_____Initial Report	**Grand Total:**
0 = Do Not Suffer From this Ever or Almost Ever	_____ Follow-up	
1 = Suffer OCCASSIONALLY (Less than 2 times a week) is not severe		
2 = Suffer FREQUENTLY (2 or more times per week,) is not severe		
3 = Suffer OCCASSIONALLY and is Severe		
4 = Suffer FREQUENTLY and is severe		

CONSTITUTIONAL
_____ Fatigue (sluggish, tired)
_____ Hyperactive (nervous energy)
_____ Restless (can't relax/sit still)
_____ Don't Sleep well at Night / **Snore**
_____ Tired in the Morning
_____ **TOTAL (0-20)**

Ambulation/walking
_____ Pain while walking continuously
_____ Pain while walking intermittently
_____ Pain with certain Shoes
_____ Unsteady
_____ **TOTAL (0 – 16)**

Head / EARS
_____ Headache (any Kind)
_____ Earache
_____ Ear Infection
_____ Ringing in EAR
_____ Itchy Ears
_____ Discharge From Ears
_____ **TOTAL (0-24)**

SKIN
_____ Blemishes, Acne
_____ Rashes, Hives
_____ Eczema
_____ "Rosy" Cheeks
_____ **TOTAL (0-16)**

GENITOURINARY
____ Increased Urinary
____ Painful Urination
____ Difficult Urination/Dribble
_____ **TOTAL (0-12)**

NASAL/SINUS
_____ Post Nasal Drip
_____ Sinus Pain
_____ Runny Nose
_____ Stuffy Nose
_____ Sneezing
_____**TOTAL (0-20)**

ENT - Mouth/Throat
_____ Sore Throat
_____ Swollen Throat
_____ Swelling of Lips/Tongue
_____Gagging /Throat Cleaning
_____ Lesions ("Canker Sores")
_____ **TOTAL (0-20)**

LUNGS
____ Wheezing (Asthma or like Symptoms)
____ Chest Congestion
____ Non-Productive Coughing
____ Productive Coughing
____ Shortness of Breath
_____ **TOTAL (0-20)**

MUSCULOSKELETAL
____ Joint Pains/Aching
____ Stiff Joints
____ Muscle Aches
____ Stiff Muscles
____ Arthritis (Diagnosed)
_____ **TOTAL (0-20)**

MISCELANIOUS
____ Memory Loss
____ Dizziness
_____ **TOTAL (0-8)**

CARDIOVASCULAR
____ Irregular Heartbeat
____ High Blood Pressure
____ Chest Pain
____ Shortness of Breath
____ Palpitations
_____ **TOTAL (0-20)**

DIGESTIVE
____ Heartburn/Esoph.Reflux
____ Stomach Pains/Cramps
____ Intestinal Pains/Cramps
____ Constipation
____ Diarrhea
____ Bloating Sensation
____ Gas (of any Kind)
____ Nausea, Vomiting
____ Painful Elimination
____ Stool - Discolored

_____ **TOTAL (0-40)**

WEIGHT MANAGMENT
_____ Actual Weight
_____ Approximate Height
_____ Fluctuating Weight
_____ Food Cravings
_____ Water Retention
_____ Binge Eating or Drinking
_____ Purging (any method)
_____ **TOTAL (0-20)**

Total Score: _____

Patient Signature: _____Physician Signature: _____

Start time: _____ Stop Time:_____ MA: Signature: _____