Symptoms Checklist

Name____Date____________________

Do you have or have you had any of the following:

If you experience a listed problem, please insert a number (1-5) in the "YES" column corresponding to the severity of your symptoms: 1 being minimal and 5 severe.	YES	NO	RARELY	CONSTANT	DAILY	WEEKLY	MONTHLY	Comments	OFFICE USE ONLY: Lyme	Babesia	Ehrlichia	Bartonella	Mercury/Heavy Metals
General Well-Being													
Unexplained weight loss or gain (circle), amount #													
Extreme fatigue													
Swollen glands: list areas_____________________													
Continual infections (sinus, kidney, eye, etc.)													
Experienced a flu-like illness, after which you have not felt well since													
Symptoms seem to change or come and go													
Pain migrates to different parts of the body													
Exaggerated symptoms or worst hangover from alcohol													
Chronic pain: list areas_______________________													
Tooth pain													
Nose bleeds													
Allergies													
Head, Face, Neck													
Unexplained hair loss													
Headaches													
Twitching of facial or neck muscles													
Facial paralysis (Bell's Palsy)													
Tingling of nose, cheek, or face													
Stiff or painful neck													
Jaw pain or stiffness													
Sore throat													
Eyes, Vision													
Double or blurry vision													
Increased floating spots													
Pain in eyes													
Swelling around eyes													
Oversensitive to light													
Sensitive to flashing lights													
Blind spots													
Night blindness													
Page 1 Subtotal													

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Ears / Hearing													
Decreased hearing in one or both ears													
Buzzing or ringing in ears													
Pain in ears													
Dizziness													
Motion sickness													
Digestive & Excretory													
Diarrhea													
Constipation													
Irritable bladder (trouble starting or stopping)													
Upset stomach, nausea, or vomitting													
Musculoskeletal System													
Joint pain or swelling: list joints_______________													
Stiffness of joints, back, or neck													
Muscle pain or cramps													
Muscle tightness													
Feeling like your bones hurt													
Have you been diagnosed with arthritis													
Respiratory & Circulatory Systems													
Shortness of breath													
Chest pain or rib soreness													
Heart seems to have extra beats or racing pulse													
Any history of heart problems													
Loss of sex drive													
Unexplained menstrual pain													
Unexplained breast pain													
Unexplained milk production													
Testicular or pelvic pain													
Temperature Control													
Body temperature fluctuations													
Flushing													
Intolerance to heat or cold													
Decreased body temperature (below 98 degrees)													
Low-grade fevers													
Night sweats													
Chills													
Page 2 Subtotal													

Name____

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Name____Date_______________________

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Neurologic System													
Headaches or migrates													
Pressure in head													
Numbness anywhere													
Tingling or pinprick sensations													
Burning sensations													
Crawling sensations under the skin													
Stabbing sensations													
Tremors													
Twitching													
Fainting													
Spastic movements													
Do you drop objects often?													
Are you accident prone?													
Psychological													
Sudden or abrupt mood swings													
Unusual depression													
Disorientation (getting or feeling lost)													
Feeling as if you are losing your mind													
Explosive anger													
Decreased frustration tolerance													
Paranoia													
Overemotional reactions or crying easily													
Sleeping too much													
Difficulty falling or staying asleep													
Do you think about suicide?													
Do you have homicidal thoughts?													
Do you have generalized anxiety?													
Have you decreased social functioning?													
Has your job or school performance descreased?													
Are you obsessive/compulsive?													
Page 3 Subtotal													
Page 2 Subtotal													
Page 1 Subtotal													
Multiply by			5	4	3	2	1						
TOTAL													

Name____