

Health Profile

NAME _____

DATE _____

Rate each of the following symptoms based upon your typical health profile for: Past 30 days

Point Scale	0	Never or almost never have the symptom	3	Frequently have it, effect is not severe
	1	Occasionally have it, effect is not severe	4	Frequently have it, effect is severe
	2	Occasionally have it, effect is severe		

HEAD _____
 _____ Headaches
 _____ Faintness
 _____ Dizziness
 _____ Insomnia
 _____ **TOTAL**

EYES _____
 _____ Watery or itchy eyes
 _____ Swollen, reddened or sticky eyelids
 _____ Bags or dark circles under eyes
 _____ Blurred or tunnel vision
 _____ (does not include near-
 or far-sightedness)
 _____ **TOTAL**

EARS _____
 _____ Itchy ears
 _____ Earaches, ear infections
 _____ Drainage from ear
 _____ Ringing in ears, hearing loss
 _____ **TOTAL**

NOSE _____
 _____ Stuffy nose
 _____ Sinus problems
 _____ Hay fever
 _____ Sneezing attacks
 _____ Excessive mucus formation
 _____ **TOTAL**

**MOUTH/
 THROAT** _____
 _____ Chronic coughing
 _____ Gagging, frequent need to clear throat
 _____ Sore throat, hoarseness, loss of voice
 _____ Swollen or discolored tongue, gums
 _____ or lips
 _____ Canker sores
 _____ **TOTAL**

SKIN _____
 _____ Acne
 _____ Hives, rashes, dry skin
 _____ Hair loss
 _____ Flushing, hot flashes
 _____ Excessive sweating
 _____ **TOTAL**

HEART _____
 _____ Irregular or skipped heartbeat
 _____ Rapid or pounding heartbeat
 _____ Chest pain
 _____ **TOTAL**

LUNGS _____
 _____ Chest congestion
 _____ Asthma, bronchitis
 _____ Shortness of breath
 _____ Difficulty breathing
 _____ **TOTAL**

**DIGESTIVE
 TRACT** _____
 _____ Nausea, vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating feeling
 _____ Belching, passing gas
 _____ Heartburn
 _____ Intestinal/stomach pain
 _____ **TOTAL**

**JOINTS /
 MUSCLE** _____
 _____ Pain or aches in joints
 _____ Arthritis
 _____ Stiffness or limitation of movement
 _____ Pain or aches in muscles
 _____ Feeling of weakness or tiredness
 _____ **TOTAL**

WEIGHT _____
 _____ Binge eating/drinking
 _____ Craving certain foods
 _____ Excessive weight
 _____ Compulsive eating
 _____ Water retention
 _____ Underweight
 _____ **TOTAL**

**ENERGY /
 ACTIVITY** _____
 _____ Fatigue, sluggishness
 _____ Apathy, lethargy
 _____ Hyperactivity
 _____ Restlessness
 _____ **TOTAL**

MIND _____
 _____ Poor memory
 _____ Confusion, poor comprehension
 _____ Poor concentration
 _____ Poor physical coordination
 _____ Difficulty in making decisions
 _____ Stuttering or stammering
 _____ Slurred speech
 _____ Learning disabilities
 _____ **TOTAL**

EMOTIONS _____
 _____ Mood swings
 _____ Anxiety, fear, nervousness
 _____ Anger, irritability, aggressiveness
 _____ Depression
 _____ **TOTAL**

OTHER _____
 _____ Frequent illness
 _____ Frequent or urgent urination
 _____ Genital itch or discharge
 _____ **TOTAL**

GRAND TOTAL _____