

Initial Symptom Survey

Date: **April to July 2020** Patient Name: **Female in 50s** Provided by Registered Dietitian: **Lila Ojeda, MS, RDN, CSCS, CLT.** Website: **www.LO-Solutions.com**

INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST MONTH.** Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed. Note score in the boxes to the left of symptoms. Also note the number of missed work days in the last month due to illness.

SCALE OF SYMPTOM POINTS	Grand Total:	# Missed Work Days
IF you did not suffer from the symptom ever or almost never, leave it blank. 1 = OCCASIONALLY (less than 2 times per week), and symptom was MILD 2 = FREQUENTLY (2 or more times per week), and symptom was MILD 3 = OCCASIONALLY (less than 2 times per week), and symptom was SEVERE 4 = FREQUENTLY (2 or more times per week), and symptom was SEVERE	42	→ ∅

CONSTITUTIONAL	NASAL/SINUS	MUSCULOSKELETAL
Fatigue (sluggish, tired) Hyperactive (nervous energy) Restless (can't relax/sit still) Daytime sleepiness 2 Insomnia at night Malaise (feeling lousy) Seizures 2 TOTAL (0-28)	2 Post nasal drip Sinus pain Runny nose Stuffy nose Sneezing 2 TOTAL (0-20)	2 Joint pains 2 Stiff joints Muscle aches Stiff muscles Ticks (facial or otherwise) Muscle spasms 2 Muscle cramps 6 TOTAL (0-28)
EMOTIONAL/MENTAL	MOUTH/THROAT	CARDIOVASCULAR
1 Depression 2 Anxiety (fears, uneasiness) Mood swings (rapid changes) Irritability 1 Forgetfulness Lack of concentration/Brain fog Low sex drive 4 TOTAL (0-28)	Sore throat Swollen throat Swelling/burning lips/tongue 2 Gagging/throat clearing Canker sores Difficulty swallowing 2 TOTAL (0-24)	Irregular heartbeat High blood pressure TOTAL (0-8)
HEAD/EARS	LUNGS	DIGESTIVE
1 Headache (not migraine) Migraine Earache Ear infection Ringing in ears 1 Itchy ears Discharge from ears Sensitivity to sound 2 TOTAL (0-32)	2 Dry cough Wet cough Shortness of breath 2 TOTAL (0-20)	1 Heartburn/reflux Stomach pains/cramps 2 Intestinal pains/cramps Constipation 1 Diarrhea 2 Bloating sensation 2 Gas (of any kind) Nausea Vomiting Painful elimination 7 TOTAL (0-40)
SKIN	EYES	WEIGHT MANAGEMENT
Blemishes, acne Rashes or hives Eczema or psoriasis "Rosy" cheeks Flushing 4 Itchy skin 4 TOTAL (0-24)	Red or swollen eyes Watery eyes 2 Itchy eyes 4 Dark circles or "bags" Sensitivity to light Aura 6 TOTAL (0-24)	Current weight: Lost 10# 2 Fluctuating weight 2 Food cravings Water retention Binge eating or drinking Purging (all methods) 4 TOTAL (0-20)
	GENITOURINARY	LIST OTHER SYMPTOMS:
	1 Increased urinary frequency Painful urination Bladder pain Bedwetting 1 TOTAL (0-16)	