



Patient Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

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

HEAD	<input type="text"/> Headaches <input type="text"/> Faintness <input type="text"/> Dizziness <input type="text"/> Insomnia	Total _____
-------------	---	--------------------

EYES	<input type="text"/> Watery or itchy eyes <input type="text"/> Swollen, reddened or sticky eyelids <input type="text"/> Bags or dark circles under eyes <input type="text"/> Blurred or tunnel vision <i>(Does not include near or far-sightedness)</i>	Total _____
-------------	---	--------------------

EARS	<input type="text"/> Itchy ears <input type="text"/> Earaches, ear infections <input type="text"/> Drainage from ear <input type="text"/> Ringing in ears, hearing loss	Total _____
-------------	--	--------------------

NOSE	<input type="text"/> Stuffy nose <input type="text"/> Sinus problems <input type="text"/> Hay fever <input type="text"/> Sneezing attacks <input type="text"/> Excessive mucus formation	Total _____
-------------	--	--------------------

MOUTH/THROAT	<input type="text"/> Chronic coughing <input type="text"/> Gagging, frequent need to clear throat <input type="text"/> Sore throat, hoarseness, loss of voice <input type="text"/> Swollen or discolored tongue, gums, lips <input type="text"/> Canker sores	Total _____
---------------------	---	--------------------

SKIN	<input type="text"/> Acne <input type="text"/> Hives, rashes, dry skin <input type="text"/> Hair loss <input type="text"/> Flushing, hot flashes <input type="text"/> Excessive sweating	Total _____
-------------	--	--------------------

HEART	<input type="text"/> Irregular or skipped heartbeat <input type="text"/> Rapid or pounding heartbeat <input type="text"/> Chest pain	Total _____
--------------	--	--------------------

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

DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated 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 _____

KEY

Add individual scores and total each group. Add each group scores and give a grand total.
 • Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100