# SYMPTOM SCORE SHEET

*Date* _____

Complete this evaluation form immediately. It is important to have an accurate record of where you began in order to see the changes in your health over time. Remember to update your symptom score sheet for every interval (2 weeks, 1 month, etc). Put a 1, 2, 3 or 4 beside each item that describes your symptoms, using 1 for rare and 4 for constant.

| SYMPTOM | Today | 2 Weeks | 1 Month | 2 Months | 3 Months |
|---|---|---|---|---|---|
| Allergies / Hay Fever | | | | | |
| Bloated Feeling | | | | | |
| Blood Sugar Problems | | | | | |
| Body Odor | | | | | |
| Bowel Gas | | | | | |
| Cold Hands and Feet | | | | | |
| Constipation / Diarrhea | | | | | |
| Cuts and Bruises Heal Slowly | | | | | |
| Difficulty Getting Up in Morning | | | | | |
| Difficulty Falling Asleep | | | | | |
| Drink Coffee / Tea / Pop | | | | | |
| Eye Problems – Glasses, Poor Night Vision | | | | | |
| Feel Stressed Out | | | | | |
| Food Cravings | | | | | |
| Foot Pains | | | | | |
| Frequent Colds and Infections | | | | | |
| Frequently Take Pain Killers | | | | | |
| Fuzzy Thinking | | | | | |
| Headaches / Migraines | | | | | |
| Heartburn / Indigestion | | | | | |
| Hemorrhoids | | | | | |
| High / Low Blood Pressure | | | | | |
| Joint Pain | | | | | |
| Low Energy / Often Feel Tired | | | | | |
| Menstrual Cramps / Moody / PMS | | | | | |
| Moods of Depression / Anxiety | | | | | |
| Muscle Cramps | | | | | |
| Night Sweats | | | | | |
| On Medication / Drugs | | | | | |
| Poor Concentration | | | | | |
| Shortness of Breath | | | | | |
| Skin Problems – Dry Itchy, Acne | | | | | |
| Varicose Veins | | | | | |
| Weak Bladder, Incontinence | | | | | |
| Weak fingernails / Unhealthy hair | | | | | |