Initial Symptom Checklist

Patient Name: _____

Present Weight: _____

Immune Test Date: _____

Date Diet Started: _____ **Checklist Date:** _____

Medical Diagnosis (if any): _____

SYMPTOM POIINT SCALE:
Use the point scale to rate your symptoms based on how you've been feeling over the past 30 days.

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

Be sure to enter your Symptom Progress Checklist scores in the comparison chart on page 40

DIGESTIVE TRACT
_____ Belching
_____ Bloated feeling
_____ Constipation
_____ Diarrhea
_____ Nausea
_____ Passing gas
_____ Stomach pains
_____ Vomiting
TOTAL

EARS
_____ Drainage from ear
_____ Ear aches
_____ Ear Infections
_____ Hearing loss
_____ Itchy ears
_____ Ringing in ears
_____ **TOTAL**

EMOTIONS
_____ Aggressiveness
_____ Anxiety/fear
_____ Depression
_____ Irritability/anger
_____ Mood swings
_____ Nervousness
_____ **TOTAL**

ENERGY & ACTIVITY
_____ Apathy
_____ Fatigue
_____ Hyperactivity
_____ Lethargy
_____ Restlessness
_____ Sluggishness
_____ **TOTAL**

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

EYES
_____ Blurred vision
_____ Dark circles
_____ Itchy eyes
_____ Sticky eyelids
_____ Swollen eyelids
_____ Watery eyes
_____ **TOTAL**

JOINT & MUSCLES
_____ Aches in muscles
_____ Arthritis
_____ Feeling of weakness
_____ Limited movement
_____ Pain in joints
_____ Stiffness
_____ **TOTAL**

LUNGS
_____ Asthma/bronchitis
_____ Check congestion
_____ Difficulty breathing
_____ Shortness of breath
_____ Wheezing
_____ **TOTAL**

MIND
_____ Confusion
_____ Learning disabilities
_____ Poor concentration
_____ Poor memory
_____ Stuttering/stammering
_____ **TOTAL**

MOUTH & THROAT
_____ Canker sores
_____ Chronic coughing
_____ Gagging
_____ Often clear throat
_____ Sore throat
_____ Swollen tongue/lips/gums
_____ **TOTAL**

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

SKIN
_____ Acne
_____ Dermatitis
_____ Eczema
_____ Excessive sweating
_____ Flushing/hot flashes
_____ Hair loss
_____ Hives/rashes
_____ Itching
_____ **TOTAL**

WEIGHT
_____ Binge eating
_____ Compulsive eating
_____ Cravings
_____ Excessive weight
_____ Underweight
_____ Water retention
_____ **TOTAL**

OTHER
_____ Anaphylactic reactions
_____ Chest pains
_____ Frequent illness
_____ Genital itch
_____ Irregular heartbeat
_____ Rapid heartbeat
_____ Urgent urination
_____ **TOTAL**

_____ **GRAND TOTAL**