CORE WELLNESS
CENTRES

Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for : Past 30 days ☐ Past 48 hours ☐

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

___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 sighted

Total: ___

EARS

___Itchy ears

___Earaches / Ear infections

___Drainage from ears

___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 / discoloured tongue/Gum/Lips

___Canker sores

Total:___

ENERGY / ACTIVITY

___Fatigue/ Sluggishness

___Apathy / Lethargy

___Hyperactivity

___Restlessness **Total:___**

WEIGHT

___Binge eating / Drinking

___Craving certain foods

___Excessive weight

___Compulsive eating

___Water retention

___Underweight **Total: ___**

EMOTIONS

___Mood swings

___Anxiety / Fear / Nervousness

__Anger / Irritability / Aggressiveness

___Depression **Total:___**

MIND

___Poor memory

___Confusion / Poor comprehension

___Poor concentration

___Poor physical condition

___Difficulty in making decisions

___Stuttering / Stammering

___Slurred speech

___Learning disabilities **Total:___**

JOINTS / MUSCLE

___Pain or Aches in joints

___Arthritis

___Stiffness or limited movement

___Pain or Aches in Muscles

___Feeling of weakness or tiredness

Total:___

LUNGS

___Chest Congestion

___Asthma, Bronchitis

___Shortness of breath

___Difficulty breathing

Total:___

HEART

___Irregular or skipped heartbeat

___Rapid or pounding heartbeat

___Chest pain

Total:___

DIGESTIVE TRACT

___Nausea / Vomiting

___Diarrhoea

___Constipation

___Bloated feeling

___Belching / Passing gas

___Heartburn

___Intestinal / Stomach pain

Total: ___

OTHER

___Frequent illness

___Frequent or urgent urination

___Genital Itch or discharge **Total:___**

SKIN

___Acne

___Hives / Rashes / Dry Skin

___Hair loss

___Flushing / Hot flashes

___Excessive sweating

Total:___

TOTAL: