



Name: \_\_\_\_\_

Date: \_\_\_\_\_

### SYMPTOM CHECKLIST

**Instructions:** Please note the symptoms in the list that you experience on a regular basis. Place an "X" in the column corresponding the **frequency** and **severity** of each symptom. If you **rarely** have the symptom, just leave that line **blank**.

SYMPTOM	<u>Symptom Frequency</u>				<u>Symptom Severity</u>		
	1=A Few days a Month	2=A Few days a Week	3=Almost Every Day		1=Mildly Noticeable	2=More Bothersome	3=Severe/Debilitating
	1	2	3		1	2	3
Aches & Pains							
Fatigue (All-Day)							
Fatigue (Morning)							
Fatigue (Afternoon)							
Fatigue (Evening)							
Irritability							
Mood Swings							
Foggy Mind							
Anxiety							
Can't Fall Asleep							
Interrupted Sleep							
Waking Up Unrefreshed							
Carb. Cravings							
Depression							
Heavy Periods							
Cyclic PMS Symptoms							
Breakthrough Bleeding							
Hot Flashes							
Breast Tenderness							
Headaches							
Bloating							
Night Sweats							
Low Sex Drive							
Weight Gain							
Vaginal Dryness							
Hair Loss							
Dry, Thinning Skin							
Cold Body Temperature							

*Just Check* →  
*"Severity"* →  
*for Each of These* →  
*Symptoms* →

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### LIFESTYLE QUESTIONS

Do you smoke cigarettes? \_\_\_\_ YES \_\_\_\_ NO If so, how many cigarettes per day? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_ YES \_\_\_\_ NO If so, how many drinks per week? \_\_\_\_\_

Do you use any street drugs? \_\_\_\_ YES \_\_\_\_ NO *(all answers are confidential)*

How many caffeine-containing drinks do you have a day? \_\_\_\_\_ *(coffee, tea, sodas, energy drinks)*

What time do you go to bed at night? \_\_\_\_\_ How long until you fall asleep? \_\_\_\_\_

How many times do you wake up a night? \_\_\_\_\_ Do you go to sleep with the TV on? \_\_\_\_\_

What do you do when you wake up at night? \_\_\_\_\_

What time do you wake up in the morning on a typical work day? \_\_\_\_\_

Do you take anything to help you fall asleep? \_\_\_\_\_

Do you eat after 8PM? \_\_\_\_ YES \_\_\_\_ NO Do you feel refreshed when you wake up? \_\_\_\_\_

Do you exercise for at least 30 minutes at a time, at least 3 days per week? \_\_\_\_ YES \_\_\_\_ NO

What do you do for exercise? \_\_\_\_\_

What time of day do you usually exercise? \_\_\_\_\_

How many meals a day do you eat? \_\_\_\_ Do you snack between meals? \_\_\_\_ YES \_\_\_\_ NO

Do you drink at least 64 ounces of water per day? \_\_\_\_ YES \_\_\_\_ NO

What prescription diet pills have you taken in the past? \_\_\_\_\_

What was your most successful diet? \_\_\_\_\_ How much did you lose? \_\_\_\_\_

How much weight would you realistically like to lose in the next year? \_\_\_\_\_ pounds.

### STRESS QUESTIONS

- Please **circle** all current stressors in your life.

MOVED YOUR HOME

JOB CHANGE

JOB STRESS/LOSS

ILL FAMILY MEMBERS

MARITAL PROBLEMS

DIVORCE/SEPARATION

DEATH OF SPOUSE/CHILD

FORECLOSURE/BANKRUPTCY

LEGAL PROBLEMS

NEW MARRIAGE

RETIREMENT

TROUBLE W/ IN-LAWS

PROBLEMS WITH CHILDREN

NEW PERSON LIVING WITH YOU