SYMPTOM LIST

PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PRESENT SYMPTOMS

0 = NO PROBLEMS, 5 = SEVERE

ARE YOU IMPROVING	0 1 2 3 4 5
<u>CNS</u>	
MEMORY	0 1 2 3 4 5
WORD BLOCK	0 1 2 3 4 5
BRAIN FOG	0 1 2 3 4 5
HEADACHE	0 1 2 3 4 5
MOOD SWINGS	0 1 2 3 4 5
DEPRESSION	0 1 2 3 4 5
ANGER, ANXIETY, PANIC ATTACKS	0 1 2 3 4 5
TINNITUS/RINGING IN EAR	0 1 2 3 4 5
DAY OR NIGHT SWEATS	0 1 2 3 4 5
<u>MUSCULOSKELETAL</u>	
MUSCLE PAIN, CRAMPS	0 1 2 3 4 5
NECK PAIN, CRACKING	0 1 2 3 4 5
JOINT PAIN	
SHOULDERS	0 1 2 3 4 5
ELBOWS	0 1 2 3 4 5
BACK	0 1 2 3 4 5
HIPS	0 1 2 3 4 5
KNEES	0 1 2 3 4 5
ANKLES	0 1 2 3 4 5
FEET	0 1 2 3 4 5
STRENGTH	0 1 2 3 4 5
SKIN BUMPS	0 1 2 3 4 5

CARDIAC/LUNGS

PALPITATIONS	0 1 2 3 4 5
CHEST PAINS	0 1 2 3 4 5
AIR HUNGER	0 1 2 3 4 5

GASTROINTESTINAL

ABDOMINAL PAIN	0 1 2 3 4 5
BLOATING	0 1 2 3 4 5
CONSTIPATION	0 1 2 3 4 5
DIARRHEA	0 1 2 3 4 5

URINARY

URGENCY, FREQUENCY	0 1 2 3 4 5
LEAKING	0 1 2 3 4 5
FEELS LIKE BLADDER INFECTION	0 1 2 3 4 5

ALLERGIC/IMMUNE

HISTORY OF:

RHEUMATOID ARTHRITIS	YES	NO
LUPUS	YES	NO
FIBROMYALGIA	YES	NO
PAIN IN OR JOINT SWELLING	YES	NO
ANY UNUSAL MUSCLE WEAKNESS	YES	NO

TBD SCREENING

UNUSUAL FATIGUE	YES	NO
MIGRATORY JOINT OR		
MUSCLE PAIN?	YES	NO
NUMBNESS OR TINGLING?	YES	NO
UNUSUAL MEMORY OR		
CONCENTRATION DIFFICULTY?	YES	NO
KNOWN TICK BITES?	YES	NO

ANY HISTORY OF BULLS-EYE RASH

OR UNEXPLAINED RASH? YES NO

INTEGUMETARY/SKIN

ECZEMA OR PSORIASIS? YES NO

ANY UNUSUAL BRUISING OR

BLEEDING TENDANCIES? YES NO

ANY MOLES THAT HAVE GROWN,

CHANGED COLOR, SIZE OR BLED? YES NO

NEUROPSYCH

ANY HISTORY OF:

SEIZURE DISORDER? YES NO

STROKE? YES NO

EPISODES OF DIZZINESS? YES NO

PASSING OUT? YES NO

ANY HISTORY OF OR

DO YOU HAVE?

DEPRESSION? YES NO

ANXIETY? YES NO

OTHER PSYCHOLOGICAL PROBLEMS? YES NO

DO YOU HAVE SLEEP APNEA? YES NO

(HISTORY OF STOPPING BREATHING

DURING THE NIGHT)