FirstLineTherapy®

Health Profile

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Patient Name _____ Date _____ Week _____

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/sticky eyelids
____Bags, or dark circles under eyes
____Blurred or tunnel vision
(does not include near or farsightedness)
____**TOTAL**

Ears
____Itchy ears
____Earaches, ear infections
____Drainage from ear
____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 or discolored tongue, gums, lips
____Canker sores
____ **TOTAL**

Skin
____Acne
____Hives, rashes, dry skin
____Hair loss
____Flushing, hot flashes
____Excessive sweating
____**TOTAL**

Heart
____Irregular or skipped heartbeat
____Rapid or pounding heartbeat
____Chest pain
____**TOTAL**

Lung
____Chest congestion
____Asthma, bronchitis
____Shortness of breath
____Difficulty breathing
____**TOTAL**

Digestive Tract
____Nausea, vomiting
____Diarrhea
____Constipation
____Bloated feeling
____Belching, passing gas
____Heartburn
____Intestinal/stomach pain
____**TOTAL**

Joints Muscle
____Pain or aches in joints
____Arthritis
____Stiffness or limitation of movement
____Pain or aches in muscles
____Feeling of weakness or tiredness
____**TOTAL**

Weight
____Binge eating/drinking
____Craving certain foods
____Compulsive eating
____Water retention
____Underweight
____**TOTAL**

Energy Activity
____Fatigue, sluggishness
____Apathy, lethargy
____Hyperactivity
____Restlessness
____**TOTAL**

Mind
____Poor memory
____Confusion, poor comprehension
____Poor concentration
____Poor physical coordination
____Difficulty in making decisions
____Stuttering or stammering
____Slurred speech
____Learning disabilities
____**TOTAL**

Emotions
____Mood swings
____Anxiety, fear, nervousness
____Anger, irritability, aggressiveness
____Depression
____**TOTAL**

Other
____Frequent illness
____Frequent or urgent urination
____Genital itch or discharge
____**TOTAL**

_____GRAND TOTAL