Whole Health Solutions Health Status Update

NAME _____ DATE _____ _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale			
	0 *Never* or *almost never* have the symptom	3 *Frequently* have it, effect is *not severe*
	1 *Occasionally* have it, effect is *not severe*	4 *Frequently* have it, effect is *severe*
	2 *Ocasionally* 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-sightedness)
_____ 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 or 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

LUNGS
_____ 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
_____ Excessive weight
_____ 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 _____

PLEASE ANSWER IF YOU HAVE HAD THE SYMPTOM IN THE LAST YEAR OR SINCE YOUR LAST VISIT:

(Questions below can be SKIPPED if you are here only for follow-up of REVTherapy/Health Coaching)
Have you added, changed or stopped any medications or supplements?
Have you had any of the following:

[ ]Fevers or chills?
[ ]Blackouts or fainting?
[ ]Trouble swallowing?
[ ]Painful or frequent urination ?
[ ]Blood in the urine, or kidney stones?
[ ]Any liver problems, yellow skin or eyes?
[ ]Bleeding from nose, mouth, rectum or in urine, black or tarry-looking stools?
[ ]Genital or reproductive complaints
[ ]Difficulty tolerating heat or cold (more than other people.)
[ ]Have you seen another doctor or been hospitalized since your last visit?

IF YOU CHECKED ANY OF THE ABOVE, PLEASE EXPLAIN:_____
_____
_____