Follow-Up Symptom Survey

Ver 5-14

Date:	Patient Name:	Practitioner:

INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST MONTH.** Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score to the left of EVERY symptom listed. Write the "Grand Total" at the top. Also note the number of missed work days you have had in the last month due to illness.

SCALE OF SYMPTOM POINTS

IF you did not suffer from the symptom ever or almost never, leave it blank.

1 = **OCCASIONALLY** (less than 2 times per week) and symptom **was MILD**
2 = **FREQUENTLY** (2 or more times per week) and symptom **was MILD**
3 = **OCCASIONALLY** (less than 2 times per week) and symptom **was SEVERE**
4 = **FREQUENTLY** (2 or more times per week) and symptom **was SEVERE**

Grand Total:	**# Missed Work Days:**

	CONSTITUTIONAL		**NASAL/SINUS**		**MUSCULOSKELETAL**
	Fatigue (sluggish, tired)		Post nasal drip		Joint pains
	Hyperactive (nervous energy)		Sinus pain		Stiff joints
	Restless (can't relax/sit still)		Runny nose		Muscle aches
	Daytime sleepiness		Stuffy nose		Stiff muscles
	Insomnia at night		Sneezing		Tics (facial or otherwise)
	Malaise (feeling lousy)		TOTAL (0-20)		Muscle spasms
	Seizures		**MOUTH/THROAT**		Muscle cramps
	TOTAL (0-28)		Sore throat		TOTAL (0-28)
	EMOTIONAL/MENTAL		Swollen throat		**CARDIOVASCULAR**
	Depression		Swelling/burning lips/tongue		Irregular heartbeat
	Anxiety (fears, uneasiness)		Gagging/throat clearing		High blood pressure
	Mood swings (rapid changes)		Canker sores		TOTAL (0-8)
	Irritability		Difficulty swallowing		**DIGESTIVE**
	Forgetfulness		TOTAL (0-24)		Heartburn/reflux
	Lack of concentration/Brain fog		**LUNGS**		Stomach pains/cramps
	Low sex drive		Wheezing		Intestinal pains/cramps
	TOTAL (0-28)		Chest congestion		Constipation
	HEAD/EARS		Dry cough		Diarrhea
	Headache (not migraine)		Wet cough		Bloating sensation
	Migraine		Shortness of breath		Gas (of any kind)
	Earache		TOTAL (0-20)		Nausea
	Ear infection		**EYES**		Vomiting
	Ringing in ears		Red or swollen eyes		Painful elimination
	Itchy ears		Watery eyes		TOTAL (0-40)
	Discharge from ears		Itchy eyes		**WEIGHT MANAGEMENT**
	Sensitivity to sound		Dark circles or "bags"		Current weight:
	TOTAL (0-32)		Sensitivity to light		Fluctuating weight
	SKIN		Aura		Food cravings
	Blemishes, acne		TOTAL (0-24)		Water retention
	Rashes or hives		**GENITOURINARY**		Binge eating or drinking
	Eczema or psoriasis		Increased urinary frequency		Purging (all methods)
	"Rosy" cheeks		Painful urination		TOTAL (0-20)
	Flushing		Bladder pain		**LIST OTHER SYMPTOMS:**
	Itchy skin		Bedwetting		
	TOTAL (0-24)		TOTAL (0-16)		

On a scale of 1 to 10, how closely do you feel you have followed your LEAP plan this week? _____