

Nourishing Wellness

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Symptom Survey

Name _____

Date _____

Rate each of the following symptoms based on your typical health profile for the **past 30 days**:

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	SKIN ____ Acne ____ Hives, rashes, dry skin ____ Hair loss ____ Flushing, hot flashes ____ Excessive sweating ____ Total	WEIGHT ____ Binge eating/drinking ____ Craving certain foods ____ Excessive weight ____ Compulsive eating ____ Water retention ____ Underweight ____ Total
EYES ____ Blurred or tunnel vision (does not include near or farsightedness) ____ Swollen, reddened or sticky eyelids ____ Watery or itchy eyes ____ Bags or dark circles under eyes ____ Total	HEART ____ Irregular or skipped heartbeat ____ Rapid or pounding heartbeat ____ Chest pain ____ Total	ENERGY/ ACTIVITY ____ Fatigue, sluggishness ____ Apathy, lethargy ____ Hyperactivity ____ Restlessness ____ Total
EARS ____ Itchy ears ____ Earaches, ear infections ____ Drainage from ear ____ Ringing in ears, hearing loss ____ Total	LUNGS ____ Chest congestion ____ Asthma, bronchitis ____ Shortness of breath ____ Difficulty breathing ____ Total	MIND ____ Poor memory ____ Confusion, poor comprehension ____ Poor concentration ____ Poor physical coordination ____ Difficulty making decisions ____ Stuttering or stammering ____ Slurred speech ____ Learning disabilities ____ Total
NOSE ____ Stuffy nose ____ Sinus problems ____ Hay fever ____ Sneezing attacks ____ Excessive mucus formation ____ Total	DIGESTIVE TRACT ____ Nausea, vomiting ____ Diarrhea ____ Constipation ____ Bloating feeling ____ Belching, passing gas ____ Heartburn ____ Intestinal, stomach pain ____ Total	EMOTIONS ____ Mood swings ____ Anxiety, fear, nervousness ____ Anger, irritability, aggressiveness ____ Depression ____ 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	JOINT/ MUSCLE ____ Pain or ache in joints ____ Arthritis ____ Stiffness/limitation of movement ____ Pain or ache in muscles ____ Feeling of weakness or tiredness ____ Total	OTHER ____ Frequent illness ____ Frequent or urgent urination ____ Genital itch or discharge ____ Total
GRAND TOTAL _____		