SYMPTOM PROGRESS CHECKLIST

Patient Name:

_____

Present Weight:

_____

Date Diet Started:

_____

Checklist Date:

_____

Medical Diagnosis (if any):

_____

_____

_____

I followed my program: ☐Exactly ☐Mostly ☐Hardly ☐Not at all

SYMPTOM POINT SCALE:

Use the point scale to rate your symptoms based on how you've been feeling over the past 30 days.

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

DIGESTIVE TRACT
_____Nausea & vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Stomach pains or cramps
_____Heartburn
_____Blood and/or mucous in stool
_____TOTAL

EARS
_____Itchy ears
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears
_____Hearing loss
_____Reddening of ears
_____TOTAL

EMOTIONS
_____Mood swings
_____Anxiety, fear, nervousness
_____Anger, irritability, aggressiveness
_____Argumentative
_____Frustrated, cry easily
_____Depression
_____TOTAL

ENERGY & ACTIVITY
_____Apathy, lethargy
_____Attention deficit
_____Fatigue
_____Hyperactivity
_____Restlessness
_____Poor physical condition
_____Stuttering or stammering
_____Slurred speech
_____TOTAL

EYES
_____Watery or itchy eyes
_____Red, swollen or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision
_____TOTAL

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia, sleep disorder
_____Facial flushing
_____TOTAL

HEART
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain
_____TOTAL

JOINTS & MUSCLES
_____Pains or aches in joints
_____Arthritis
_____Stiffness or limited movement
_____Pain or aches in muscles
_____Feeling of weakness or tiredness
_____Swollen, tender joints
_____Growing pains in legs
_____TOTAL

LUNGS
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty in breathing

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_____Persistent cough
_____Wheezing
_____TOTAL

MIND
_____Poor memory
_____Difficulty completing projects
_____Difficulty with mathematics
_____Underachiever
_____Poor/short attention span
_____Confusion
_____Easily distracted
_____Difficulty making decisions
_____Learning disabilities
_____TOTAL

MOUTH & THROAT
_____Chronic coughing
_____Gagging, frequent throat clearing
_____Sore throat, hoarse, loss of voice
_____Swollen or discolored tongue/lips
_____Canker sores
_____Itching on roof of mouth
_____TOTAL

NOSE
_____Stuffy nose
_____Chronically red, inflamed nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucous formation
_____TOTAL

SKIN
_____Acne
_____Itching
_____Hives, rash, dry skin
_____Hair loss
_____Flushing or hot flashes
_____TOTAL

WEIGHT
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____TOTAL

OTHER
_____Frequent illness
_____Frequent or urgent urination
_____Genital itch or discharge
_____Anal itching
_____TOTAL

_____GRAND TOTAL