

S O S

Symptom Observation Survey

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Patient Details:

Name _____ Date _____

Sex: _____ Male _____ Female Age: _____

Contact Phone Numbers: _____ Daytime
_____ Evening

Address: _____

Bring in your completed questionnaire to your next visit.

Scoring Point Scale:

0 = never or almost never **1** = occasionally **2** = frequently **3** = almost always or always

1. Head

- ___ Headaches / Sinus Headaches
- ___ Migraines
- ___ Problems with balance (i.e. dizziness)
- ___ Light headed feeling on standing
- ___ Total

2. Eyes

- ___ Blurred vision
- ___ Watery, burning or itchy eyes
- ___ Sore/aching eyes sensitive to light
- ___ Dark circles or bags under eyes
- ___ Total

3. Nose/Throat

- ___ Nasal congestion/discharge
- ___ Scaly scabs in nose
- ___ Recurring sinus infections
- ___ Recurring chest infections
- ___ Sneezing attacks
- ___ Nasal drip down back of throat
- ___ Coating on tongue
- ___ Frequent need to clear throat
- ___ Sore throat
- ___ Sores/blisters inside mouth
- ___ Chronic cough
- ___ Total

4. Ears

- ___ Itchy ears
- ___ Discharge/excess wax
- ___ Pressure/pain in ears
- ___ Ringing in ears
- ___ Recurring ear infections
- ___ Hearing loss
- ___ Red or burning ears (after meals)
- ___ Total

5. Lungs

- ___ Chest congestion
- ___ Shortness of breath on exertion
- ___ Asthma
- ___ Total

6. Cardiovascular

- ___ Rapid or thumping heartbeat
- ___ Irregular or skipped heartbeat
- ___ Chest pain on exertion
- ___ Leg calf pain on exertion
- ___ Total

7. Gastrointestinal

- ___ Nausea
- ___ Vomiting
- ___ Abdominal cramping relieved by BM
- ___ Feeling of incomplete emptying after a BM
- ___ Constipation
- ___ Abdominal bloating (especially after meals)
- ___ Abdominal pain
- ___ Flatulence / passing gas
- ___ Heartburn / indigestion
- ___ Diarrhea
- ___ Belching / burping
- ___ Total

8(a) Intestinal Elimination

- ___ Straining required to eliminate stools
- ___ Mucus and/or blood present in stool
- ___ Hard, small stools
- ___ Greasy floating stools
- ___ Foul smelling stools
- ___ Total

Scoring Point Scale:

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8(b) Urinary Tract/Skin Elimination

- Frequent/urgent need to urinate
- Frequent urination at night
- Burning or painful urination
- Strong odor noticed after urination
- Strong smelling perspiration

_____ **Total**

9. Skin

- Dry or cracked skin
- Hives or rashes
- Itchy skin
- Fungus/thrush infection of skin/nails
- Flushing or excessive perspiration
- Night sweats (excessive sweating at night)
- Excessive loss of hair from your head
- Loss of hair from eyebrows

_____ **Total**

10. Muscles/joints

- Muscle pain
- Muscle weakness
- Joint pain
- Joint Stiffness
- Muscle cramps
- Involuntary muscle twitching
- Bone deformity or swelling
- Decreased mobility/movement

_____ **Total**

11. Sensitivities

- Do you have a low tolerance of alcohol?
- Sensitive to chemical odors
(cleaning agents, fertilizers, exhaust, etc.)
- Sensitive to fragrances / perfumes
- React to caffeine containing foods / beverages
- React to foods containing onions or garlic
- React to preservatives / additives added to foods
- Are your symptoms aggravated by exposure to second-hand smoke?
- How often are you exposed to second-hand smoke?

_____ **Total**

12. Energy / Activity

- Do you experience ongoing fatigue
- Increased fatigue after even minimal effort
- Increased fatigue after meals
- Apathy/indifference to things going on around you
- Restlessness/Hyperactivity
- How often do you exercise
(3 = never; 2 = 1-2 times a week; 1 = 3-4 times a week; 0 = 5-7 times a week)
- Rate your level of exercise
(2 = mild [walking]; 1 = moderate [pace walkin/ low impact aerobics] 0 = athletic)

_____ **Total**

13. Mind / Memory

- Decreased memory
- Poor concentration
- Reduced comprehension
- Difficulty making decisions
- Brain "fogginess" / fuzzy thinking
- Poor short term memory
- Difficulty with speech / reading out loud

_____ **Total**

14. Sleep

- Trouble getting to sleep
- Trouble staying asleep
- Restless sleep
- Unrefreshing sleep
- Desire for increased sleeping hours
- Do you experience daily stress?
- Do you feel anxious?

_____ **Total**

15. Weight

- Weight gain
- Weight loss
- Unable to lose weight
- Unable to gain weight
- Compulsive hunger
- Binge eating / drinking

_____ **Total**

16. Diet

- Do you eat fried foods?
- Do you eat deep fried foods?
- Do you eat margarine or processed foods made with hydrogenated oils?
- Do you eat a lot of fatty animal proteins?
(e.g. beef, lamb, chicken, cheese?)
- Do you drink carbonated soft drinks?
- Do you consume alcohol?
- Do you consume caffeine containing drinks?
(e.g. coffee, cola, etc.)
- Do you drink 6 or more glasses of water daily?
(3=No, 0=Yes)

_____ **Total**

17. Taste

- Cravings for foods containing yeast
(Bread, beer, wine, cheese, etc.)
- Cravings for any type of sweet foods / beverages
- Cravings for chocolate containing foods / beverages
- Cravings for complex starches
(pasta, crackers, potatoes, etc.)

_____ **Total**

18. Other

- How often do you feel "lousy"?

_____ **Total**

TOTAL PAGE 1 _____ + **TOTAL PAGE 2** _____ = **GRAND TOTAL:** _____

Bring in your completed questionnaire to your next visit.