In Harmony Wellness Center
Total Health Resonance
Symptom Questionnaire

Last Name: _____First:_____ Date:_____

Rate each of the symptoms you have experienced in the **past month** by circling: 0=never have this, 1=occasionally have it but not severe, 2=occasionally have it and severe, 3=frequently have it and ranges from not severe to severe

Symptom	Never Have This	Occas. not Severe	Occas. and Severe	Frequent not Severe to Severe
Head				
Headaches	0	1	2	3
Bags/circles under eyes	0	1	2	3
Itchy/red/swollen eyes	0	1	2	3
Blurry vision	0	1	2	3
Ringing in ears/hearing loss	0	1	2	3
Itching in ears	0	1	2	3
Stuffy/runny nose	0	1	2	3
Hay fever/sneezing attacks	0	1	2	3
Sinus problems	0	1	2	3
Chronic coughing/gagging-need to clear throat	0	1	2	3
Sore throat/hoarseness	0	1	2	3
Swollen, sore or discolored tongue, gums, lips	0	1	2	3
Swallowing problems	0	1	2	3
TMJ/Jaw or Teeth problems	0	1	2	3
Metallic taste	0	1	2	3
Dizziness	0	1	2	3
Total the circled numbers from above section >>>				
Skin				
Acne	0	1	2	3
Hives/rashes/dry skin	0	1	2	3
Flushing/hot flashes	0	1	2	3
Bruising	0	1	2	3
Hair loss	0	1	2	3
Brown spots/age spots	0	1	2	3
Excessive sweating	0	1	2	3
Total the circled numbers from above section >>>				
Heart and Lungs				
Chest congestion	0	1	2	3
Wheezing	0	1	2	3
Shortness of breath	0	1	2	3
Chest pain	0	1	2	3
Rapid heart beat/irregular heart beat	0	1	2	3
Water retention	0	1	2	3
Total the circled numbers from above section >>>				

Digestion				
Nausea, vomiting	0	1	2	3
Constipation	0	1	2	3
Diarrhea	0	1	2	3
Bloated feeling	0	1	2	3
Intestinal/stomach pain	0	1	2	3
Belching/passing gas	0	1	2	3
Food allergies/intolerances/sensitivities	0	1	2	3
Total the circled numbers from above section >>>				
Joints and Muscles				
Pain/aches/swelling in joints	0	1	2	3
Stiffness/limited movement	0	1	2	3
Pain/aches in muscles	0	1	2	3
Muscle weakness	0	1	2	3
Unusual shakiness (tremors) of hands/arms	0	1	2	3
Total the circled numbers from above section >>>				
Energy and Sleep				
Easily fatigued	0	1	2	3
Wake up often at night	0	1	2	3
Wake up tired	0	1	2	3
Sleeping in afternoon	0	1	2	3
Hyperactivity	0	1	2	3
Restlessness	0	1	2	3
Total the circled numbers from above section >>>				
Brain/Emotions				
Poor memory/forgetfulness	0	1	2	3
Difficulty concentrating	0	1	2	3
Difficulty making decisions	0	1	2	3
Mood swings	0	1	2	3
Anxiety, fear, nervousness	0	1	2	3
Anger, irritability	0	1	2	3
Depression	0	1	2	3
Decreased sex drive	0	1	2	3
Craving certain foods	0	1	2	3
Binge/compulsive eating or drinking	0	1	2	3
Total the circled numbers from above section >>>				
Infections				
Frequent infections including yeast, parasites, etc.	0	1	2	3
Frequent illness	0	1	2	3
Frequent or urgent urination	0	1	2	3
Genital itch or discharge	0	1	2	3
Total the circled numbers from above section >>>				
GRAND TOTAL OF ALL SECTIONS >>>				

How many bowel movements do you have every week?_____ How many per day?_____

Height:_____feet _____inches

Weight: _____pounds