Kambeitz Chiropractic
Health & Wellness Center, P.C.

Empowering you to live your best life.

8WW 8 WEEKS TO WELLNESS

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Medical Symptoms Questionnaire

PATIENT NAME: _____ **DATE:** _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

POINT SCALE
0 - Never or almost never have this 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 0 _____

EYES
_____ Watery or Itchy Eyes
_____ Swollen, Reddened or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision
(does not include near or far-sightedness)
TOTAL 0 _____

EARS
_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage from Ear(s)
_____ Ringing in Ears, Hearing Loss
TOTAL 0 _____

NOSE
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation
TOTAL 0 _____

MOUTH/THROAT
_____ Chronic Coughing
_____ Gagging, Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness, Loss of Voice
_____ Swollen or Discolored Tongue, Gums or Lips
_____ Canker Sores
TOTAL 0 _____

ENERGY/ACTIVITY
_____ Fatigue, Sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness
TOTAL 0 _____

WEIGHT
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight
TOTAL 0 _____

EMOTIONS
_____ Mood Swings
_____ Anxiety, Fear, Nervousness
_____ Anger, Irritability, Aggressiveness
_____ Depression
TOTAL 0 _____

MIND
_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Difficulty in Making Decisions
_____ Stuttering or Stammering
_____ Slurred Speech
_____ Learning Disabilities
TOTAL 0 _____

SKIN
_____ Acne
_____ Hives, Rashes or Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating
TOTAL 0 _____

LUNGS
_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing
TOTAL 0 _____

HEART
_____ Irregular or Skipped Heartbeats
_____ Rapid or Pounding Heartbeat
_____ Chest Pain
TOTAL 0 _____

DIGESTIVE TRACT
_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching, Passing Gas
_____ Heartburn
_____ Intestinal/Stomach Pain
TOTAL 0 _____

OTHER
_____ Frequent Illness
_____ Frequent or Urgent Urination
_____ Genital Itch or Discharge
TOTAL 0 _____

JOINTS/MUSCLES
_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limited Movement
_____ Pain or Aches in Muscles
_____ Feeling of Weakness or Tiredness
TOTAL 0 _____

GRAND TOTAL 0 _____