Symptom Checklist

Name: ______________________________________ Date: ______________________

Please check any of the following symptoms you experience frequently or have a tendency towards.

___ Fatigue/Low Energy  ___ Difficulty sleeping  ___ Low back pain
___ Bruise easily  ___ Heart palpitations  ___ Frequent urination
___ Tired after eating  ___ Anxiety  ___ Knee pain
___ Low appetite  ___ Memory problems  ___ Low sex drive
___ Strong appetite  ___ Sores on the tongue  ___ High sex drive
___ Loose stools  ___ Startle easily  ___ Erectile dysfunction
___ Constipation  ___ Laugh inappropriately  ___ Night sweats
___ Abdominal bloating  ___ Pain under the ribcage  ___ Hot flashes
___ Heartburn/Reflux  ___ Excessive vaginal discharge  ___ Poor hearing
___ Post Nasal Drip  ___ Frequent irritability/Frustration  ___ Ringing in ear
___ Nausea/Vomiting  ___ Depression/Tendency to feel sad  ___ Wear socks to bed
___ Frequent hiccups or belching  ___ Frequent sighing  ___ Vaginal dryness
___ Flatulence  ___ Abdominal pain  ___ Congenital abnormalities
___ Hemorrhoids  ___ Pain under the ribcage  ___ Other symptoms not listed:
___ Excessive vaginal discharge  ___ Floaters
___ Bad breath  ___ Can’t see well at night
___ Tendency to worry/obsess  ___ Red eyes
___ Stomach ulcers  ___ Wake between 1-3am
___ Mouth sores  ___ Trouble falling asleep
___ Bleeding gums  ___ Dizziness
___ Recurrent colds/Infections  ___ Irregular periods
___ Sinus problems  ___ Inability to cry
___ Allergies  ___ Headaches/Migraines
___ Sweat easily  ___ Tight muscles
___ Do not sweat  ___ Painful periods
___ Blood or mucus in stool  ___ Skin problems
___ Pain in the teeth or gums  ___ Shortness of breath
___ People often ask you to speak up  ___ Feel Sad