Symptom Survey

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____

Top 3 symptoms, complaints, or goals: 1. _____ 2. _____ 3. _____

Past & Present Medical History:_____

Overall Wellness Score (0-10): _____ Overall Energy Score (0-10): _____

Please circle any that apply if your having problems in this area:
Temperature Circulation
Headache Dizziness Neurological System:
Ears Eyes Nose Throat Phlegm
Musculoskeletal system
Appetite Digestion Stool
Thirst Urination
Lungs Respiratory System Breathing
Energy Sleep
Reproductive System Menses
Emotions Outlook:

Additional comments that would be helpful to know:

_____
_____

Practitioners, Providers, Therapies, Modalities already in place:_____

Last Lab Values: _____

Current Herbs/Meds:

_____
_____
_____

Allergies:

_____
_____
_____

Nursing Dx:

_____
_____
_____
_____

Interventions:

_____
_____
_____
_____

Treatment Plan: _____

_____
_____
_____

Nutrients: _____

_____
_____
_____

Signature: _____