Elite Health Services
Chiropractic Concierge Clinic

Medical Symptoms Questionnaire

Patient Name:_____ **Date:**_____

Rate each of the following symptoms based on your typical health profile for the specified duration:

__ Past 48 Hours ___ Past Week ___ Past Month

Point Scale: **0** Never or almost never have the 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	**Eyes**	**Joint/Muscle**	**Weight**
_____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	_____Watery or itchy eyes _____ Swollen reddened eyes or sticky eyelids _____ Bags or dark circles under eyes _____ Blurred or tunnel vision	_____ Pain or aches in joints _____ Arthritis _____ Stiffness or limitation of movement _____ Feeling of weakness of tiredness _____ Pain or aches in muscle	_____ Binge eating/drinking _____ Craving certain foods _____ Excessive weight _____ Water retention _____ Underweight _____ Compulsive eating
Total_____	Total_____	Total_____	Total_____
Ears	**Mouth/Throat**	**Energy/Activity**	**Mind**
_____ Itchy ears _____ Earaches, ear infections _____ Drainage from ear _____ Ringing in ears, hearing loss	_____ Chronic coughing _____ Gagging, Frequent need to Clear throat _____ Sore throat, hoarseness, Loss of voice _____ Swollen or discolored Tongue, gums, lips _____ Canker sores	_____ Fatigue, sluggishness _____ Apathy, lethargy _____ Hyperactivity _____ Restlessness	_____ Poor memory _____ Confusion, poor comprehension _____ Difficulty in making decisions _____ Stuttering or stammering _____ Slurred speech _____ Learning disabilities _____ Poor concentration
Total_____	Total_____	Total_____	Total_____
Skin	**Heart**	**Emotions**	**Other**
_____ Acne _____Hives, rashes, dry skin _____ Hair loss _____ Flushing, Hot Flashes _____ Excessive sweating	_____ Chest pain _____ Irregular or skipped heart beat _____ Rapid or pounding Heartbeat	_____ Mood swings _____ Anxiety fear, nervousness _____ Anger, irritability, aggressiveness _____ Depression	_____ Frequent illness _____ Frequent or urgent urination _____ Genital itch or discharge
Total_____	Total_____	Total_____	Total_____
Lungs	**Digestive Tract**		
_____ Chest Congestion _____ Asthma, bronchitis _____ Shortness of breath _____ Difficulty breathing	_____ Diarrhea _____ Constipation _____ Bloated feeling _____ Belching, passing gas _____ Heartburn _____ Intestinal/stomach pain	**Grand Total: _____**	
Total_____	Total_____		