# DEBORA CHELSON, N.M.D.

**5102 S. Thunder Sky Way, Tucson, AZ 85747 ❖ (520) 437-9562**

## Patient Symptoms Checklist

***Rate each of the following symptoms based upon your health profile for the past 90 days.***
***Please be sure to enter a <u>point value</u>, and not just a check mark!***

**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***

---

**DIGESTIVE TRACT**

_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, or passing gas
_____ Heartburn — TOTAL _____

---

**EARS**

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss — TOTAL _____

---

**EMOTIONS**

_____ Mood swings
_____ Anxiety, fear or nervousness
_____ Anger, irritability, or aggressiveness
_____ Depression — TOTAL _____

---

**ENERGY / ACTIVITY**

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness — TOTAL _____

---

**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 _____

---

**HEAD**

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia — TOTAL _____

---

**HEART**

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain — TOTAL _____

| | | | |
|---|---|---|---|
| **JOINTS / MUSCLES** | ______ | Pain or aches in joints | |
| | ______ | Arthritis | |
| | ______ | Stiffness or limitation of movement | |
| | ______ | Pain or aches in muscles | |
| | ______ | Feeling of weakness or tiredness | TOTAL ______ |
| **LUNGS** | ______ | Chest congestion | |
| | ______ | Asthma, bronchitis | |
| | ______ | Shortness of breath | |
| | ______ | Difficulty breathing | TOTAL ______ |
| **MIND** | ______ | Poor memory | |
| | ______ | Confusion, poor comprehension | |
| | ______ | Poor concentration | |
| | ______ | Poor physical coordination | |
| | ______ | Difficulty in making decisions | |
| | ______ | Stuttering or stammering | |
| | ______ | Slurred speech | |
| | ______ | Learning disabilities | TOTAL ______ |
| **MOUTH / THROAT** | ______ | Chronic coughing | |
| | ______ | Gagging, frequent need to clear throat | |
| | ______ | Sore throat, hoarseness, loss of voice | |
| | ______ | Swollen or discolored tongue, gums, lips | |
| | ______ | Canker sores | TOTAL ______ |
| **NOSE** | ______ | Stuffy nose | |
| | ______ | Sinus problems | |
| | ______ | Hay fever | |
| | ______ | Sneezing attacks | |
| | ______ | Excessive mucus formation | TOTAL ______ |
| **SKIN** | ______ | Acne | |
| | ______ | Hives, rashes, or dry skin | |
| | ______ | Hair loss | |
| | ______ | Flushing or hot flashes | |
| | ______ | Excessive sweating | TOTAL ______ |
| **WEIGHT** | ______ | Binge eating/drinking | |
| | ______ | Craving certain foods | |
| | ______ | Excessive weight | |
| | ______ | Compulsive eating | |
| | ______ | Water retention | |
| | ______ | Underweight | TOTAL ______ |
| **OTHER** | ______ | Frequent illness | |
| | ______ | Frequent or urgent urination | |
| | ______ | Genital itch or discharge | TOTAL ______ |

**GRAND TOTAL** ____________