Dunphy PA / Nunley MD

Name_____ Date_____

A Few Questions About How You Feel

Check off each one of the symptoms in one of the columns to indicate the degree of severity which best applies to you. A check in column **0 = NONE, 1 = MILD, 2 = MODERATE, 3 = SEVERE**. Please use the designated space on the bottom of the page if you have any other problems not listed or if you choose to expand on your answer.

0	1	2	3		0	1	2	3	
				Abnormal craving for sweets					Heart palpitations (fast beats)
				Afternoon headaches					Heart pain
				Allergies					Highly emotional
				Awaken after a few hrs. sleep and can't return easily					"Pin and Needle" sensation (where_____)
				Aware of breathing heavily					Insomnia
				Bad Dreams					Joint pain (where_____)
				Backache					Lack of energy
				Blurred Vision					Leg pain when walking
				Brown spots/Bronzing of skin					Leg pain when resting
				Bruise easily					Low or High Blood Pressure
				Can't decide easily					Indigestion
				Can't get started in morning					Poor memory/ability to concentrate
				Chills					Phlebitis
				Chronic Fatigue					Pain when rotating neck or hips
				Colds hand and feet					Reduced initiative
				Chest pain (where _____)					Ringing in ears
				Chronic nervous exhaustion					Sleepy after meals
				Decreased vision/clarity					Sleepy during the day
				Decreased hearing					Shortness of breath
				Decreased sex drive					Swelling in ankles
				Dizziness or light headedness					Swishing sounds in ears
				Dry skin					Tired too often
				Dry hair					Urinary problems, (please explain_____)
				Dry or brittle nails					Varicose veins
				Earaches					Weakness
				Fatigue					Worry or feel insecure
				Forgetful					Hand(s) tremble
				Get "shaky" if hungry					Head pain

Use space below to add or describe any complaints or problems you may have.

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