FirstLineTherapy Health Profile

NAME ______________________ DATE ______________

Rate each of the following symptoms based upon your typical health profile for: □ *Past 30 days* □ *Past 48 hours*

Point Scale		
0	*Never* or *almost never* have the symptom	3 *Frequently* have it, effect is *not severe*
1	*Occasionally* have it, effect is *not severe*	4 *Frequently* have it, effect is *severe*
2	*Ocasionally* have it, effect is *severe*	

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
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

EARS

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

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
TOTAL

MOUTH/ THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums
_____ or lips
_____ Canker sores
TOTAL

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
TOTAL

HEART

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

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
TOTAL

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL

JOINTS / MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
TOTAL

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
TOTAL

ENERGY / ACTIVITY

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

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
TOTAL

EMOTIONS

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

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
TOTAL

GRAND TOTAL