*Confidential*

Name: _____ Date: _____

*Please check any of the symptoms listed below that you have experienced in the last 2 months.*

___ Frequent or severe headaches
___ Neck pains
___ Loss of balance
___ Dizzy spells
___ Blackouts/fainting

___ Blurry vision
___ Worsening eyesight
___ Double vision
___ See halos or lights
___ Eye Pains
___ Itchy or watery eyes

___ Hearing difficulties
___ Earaches
___ Noises or ringing in the ears

___ Dental problems
___ Sore or bleeding gums

___ Aching muscles or joints
___ Swollen joints
___ Back or shoulder pains
___ Weakness in arms or legs
___ Painful feet
___ Trembling
___ Numbness
___ Leg cramps

___ Wheezing or gasping
___ Frequent coughing
___ Cough up phlegm or blood
___ Chest colds

___ Skin or scalp problems
___ Itching or burning skin
___ Bruise easily

___ Recurring indigestion
___ Frequent belching
___ Nausea
___ Vomiting
___ Pain in abdomen
___ Bloated abdomen
___ Constipation
___ Loose Bowels
___ Pain or itching in rectum

___ Frequent urination
___ Involuntary escape of urine
___ Burning on urination
___ Weak urine stream
___ Difficulty starting urine
___ Constant urge to urinate

___ Rapid or skipped heartbeats
___ Chest pains
___ Shortness of breath
___ Swollen feet or ankles

___ Nervousness or anxiety
___ Nervous with strangers
___ Nail biting
___ Difficulty making decisions
___ Lack of concentration
___ Absent minded
___ Loss of memory
___ Lonely
___ Depressed
___ Frequent crying
___ Hopeless outlook
___ Difficulty relaxing
___ Worry a lot
___ Frightening thoughts/dreams
___ Feeling of desperation
___ Shy or sensitive

___ Grieving
___ Dislike criticism
___ Angered easily
___ Annoyed by little things
___ Family problems
___ Problems at work
___ Sexual difficulties
___ Change of sexual energy

___ Considered suicide
___ Sought psychiatric help

___ Loss or gain in weight
___ Loss of appetite
___ Always hungry
___ Unusual fatigue or weariness
___ Difficulty sleeping
___ Fever or chills
___ Motion sickness
___ Excessive sweating

Comments or other concerns: _____