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NAME (Print): ______________________ DATE: ______________ DOB: ______________

SYMPTOMS CHECKLIST

Please let us know if you have been experiencing any of the following symptoms or have been diagnosed with any of the following:

SYMPTOM/ DIAGNOSIS	EXPERIENCED IN THE PAST 6 MONTHS?		EXPERIENCED IN THE PAST 18-24 MONTHS?		SYMPTOM/ DIAGNOSIS	EXPERIENCED IN THE PAST 6 MONTHS?		EXPERIENCED IN THE PAST 18-24 MONTHS?	
	YES	NO	YES	NO		YES	NO	YES	NO
Anxiety					Memory Problems				
Autoimmune Disease					Mood Swings				
Blackouts					Nausea				
Blurred/Double Vision					Nervousness				
Burning Sensations					Nerve Pain				
Cardio-vascular Issues					Numbness				
Depression					Personality Changes				
Digestive Issues					Poor Balance/Coordination				
Difficulty Finding Words					Poor Concentration				
Disorientation					Ringing in The Ears				
Dizziness					Sadness				
Drowsiness/Fatigue					Seeing Stars				
Dry Mouth					Sensitivity to Cold/Heat				
Easily Distracted					Sensitivity to Light				
Feeling Like “In A Fog”					Sensitivity to Noise				
Feeling “Slowed Down”					Sleep Disturbances				
Hair Loss					Sleeping More Than Usual				
Headaches/Migraines					Tremors/Twitching				
Hearing Voices					Vacant Stares				
Hormonal Imbalance					Glassy Eyes				
Irritability					Vertigo				
Loss of Consciousness					Vomiting				
Loss of Orientation					Weakness				
Loss of Sense of Smell					Weight Gain/Loss				

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