

Follow-up Symptom Survey

Date:	Patient Name:	Practitioner:
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INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST WEEK.** Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score to the left of EVERY symptom listed. Write the "Grand Total" at the top. Also note the number of missed work days you have had in the last week due to illness.

SCALE OF SYMPTOM POINTS	Grand Total:	# Missed Work Days
IF you did not suffer from the symptom ever or almost never, leave it blank. 1 = OCCASIONALLY (less than 2 times per week) and symptom was MILD 2 = FREQUENTLY (2 or more times per week) and symptom was MILD 3 = OCCASIONALLY (less than 2 times per week) and symptom was SEVERE 4 = FREQUENTLY (2 or more times per week) and symptom was SEVERE		

CONSTITUTIONAL	NASAL/SINUS	MUSCULOSKELETAL
Fatigue (sluggish, tired)	Post nasal drip	Joint pains
Hyperactive (nervous energy)	Sinus pain	Stiff joints
Restless (can't relax/sit still)	Runny nose	Muscle aches
Daytime sleepiness	Stuffy nose	Stiff muscles
Insomnia at night	Sneezing	Tics (facial or otherwise)
Malaise (feeling lousy)	TOTAL (0-20)	Muscle spasms
Seizures	MOUTH/THROAT	Muscle cramps
TOTAL (0-28)	Sore throat	TOTAL (0-28)
EMOTIONAL/MENTAL	Swollen throat	CARDIOVASCULAR
Depression	Swelling/burning lips/tongue	Irregular heartbeat
Anxiety (fears, uneasiness)	Gagging/throat clearing	High blood pressure
Mood swings (rapid changes)	Canker sores	TOTAL (0-8)
Irritability	Difficulty swallowing	DIGESTIVE
Forgetfulness	TOTAL (0-24)	Heartburn/reflux
Lack of concentration/Brain fog	LUNGS	Stomach pains/cramps
Low sex drive	Wheezing	Intestinal pains/cramps
TOTAL (0-28)	Chest congestion	Constipation
HEAD/EARS	Dry cough	Diarrhea
Headache (not migraine)	Wet cough	Bloating sensation
Migraine	Shortness of breath	Gas (of any kind)
Earache	TOTAL (0-20)	Nausea
Ear infection	EYES	Vomiting
ringing in ears	Red or swollen eyes	Painful elimination
Itchy ears	Watery eyes	TOTAL (0-40)
Discharge from ears	Itchy eyes	WEIGHT MANAGEMENT
Sensitivity to sound	Dark circles or "bags"	Current weight:
TOTAL (0-32)	Sensitivity to light	Fluctuating weight
SKIN	Aura	Food cravings
Blemishes, acne	TOTAL (0-24)	Water retention
Rashes or hives	GENITOURINARY	Binge eating or drinking
Eczema or psoriasis	Increased urinary frequency	Purging (all methods)
"Rosy" cheeks	Painful urination	TOTAL (0-20)
Flushing	Bladder pain	LIST OTHER SYMPTOMS:
Itchy skin	Bedwetting	
TOTAL (0-24)	TOTAL (0-16)	

On a scale of 1 to 10, how closely do you feel you have followed your LEAP plan this week? _____