



# HOW HEALTHY AM I?

Take charge and track your TRUE health with this tool.

Rate each of the following symptoms based upon your typical health profile for the past 14 days.  
Point Scale:

0 - **Never or almost never** have the symptom

1 - **Occasionally** have it, effect is **not severe**

2 - **Occasionally** have it, effect is **severe**

3 - **Frequently** have it, effect is **not severe**

4 - **Frequently** have it, effect is **severe**

## HEAD

- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Faintness
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Insomnia

Total \_\_\_\_\_

## EYES

- \_\_\_\_\_ Water 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, 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 \_\_\_\_\_



<b>LUNGS</b>	<input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing	Total _____
<b>DIGESTIVE TRACT</b>	<input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating feeling <input type="checkbox"/> Belching, passing gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal / stomach pain	Total _____
<b>JOINTS / MUSCLE</b>	<input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or limitation of movement <input type="checkbox"/> Pain or aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness	Total _____
<b>WEIGHT</b>	<input type="checkbox"/> Binge eating / drinking <input type="checkbox"/> Craving certain foods <input type="checkbox"/> Excessive weight <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Water retention <input type="checkbox"/> Underweight	Total _____
<b>ENERGY / ACTIVITY</b>	<input type="checkbox"/> Fatigue, sluggishness <input type="checkbox"/> Apathy, lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Total _____
<b>MIND</b>	<input type="checkbox"/> Poor memory <input type="checkbox"/> Confusion, poor comprehension <input type="checkbox"/> Poor concentration <input type="checkbox"/> Poor physical coordination <input type="checkbox"/> Difficulty in making decisions <input type="checkbox"/> Stuttering or stammering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Learning disabilities	Total _____
<b>EMOTIONS</b>	<input type="checkbox"/> Mood swings <input type="checkbox"/> Anxiety, fear, nervousness <input type="checkbox"/> Anger, irritability, aggressiveness <input type="checkbox"/> Depression	Total _____
<b>OTHER</b>	<input type="checkbox"/> Frequent illness <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> Genital itch or discharge	Total _____ <b>Grand Total</b> _____