# Follow-up Symptom Survey

| Date: | Patient Name: | Practitioner: |
|---|---|---|

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 month due to illness.

**SCALE OF SYMPTOM POINTS**
**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**

| **Grand Total:** | **# Missed Work Days** |
|---|---|
| | |

| **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? _____