

FirstLineTherapy® Health Profile

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NAME _____

DATE _____

WEEK _____

Rate each of the following symptoms based upon your typical health profile for: Past 30 days Past 48 hours

| | | | | |
|--------------------|---|--------------------------------------------|---|------------------------------------------|
| Point Scale | 0 | Never or almost never have the symptom | 3 | Frequently have it, effect is not severe |
| | 1 | Occasionally have it, effect is not severe | 4 | Frequently have it, effect is severe |
| | 2 | Occasionally have it, effect is severe | | |

HEAD

_____ Headaches
 _____ Faintness
 _____ Dizziness
 _____ Insomnia
 _____ TOTAL

EYES

_____ Watery 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 or 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

LUNGS

_____ Chest congestion
 _____ Asthma, bronchitis
 _____ Shortness of breath
 _____ Difficulty breathing
 _____ TOTAL

**DIGESTIVE
TRACT**

_____ Nausea, vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating feeling
 _____ Belching, passing gas
 _____ Heartburn
 _____ Intestinal/stomach pain
 _____ TOTAL

**JOINTS/
MUSCLE**

_____ Pain or aches in joints
 _____ Arthritis
 _____ Stiffness or limitation of movement
 _____ Pain or aches in muscles
 _____ Feeling of weakness or tiredness
 _____ TOTAL

WEIGHT

_____ Binge eating/drinking
 _____ Craving certain foods
 _____ Excessive weight
 _____ Compulsive eating
 _____ Water retention
 _____ Underweight
 _____ TOTAL

**ENERGY/
ACTIVITY**

_____ Fatigue, sluggishness
 _____ Apathy, lethargy
 _____ Hyperactivity
 _____ Restlessness
 _____ TOTAL

MIND

_____ Poor memory
 _____ Confusion, poor comprehension
 _____ Poor concentration
 _____ Poor physical coordination
 _____ Difficulty in making decisions
 _____ Stuttering or stammering
 _____ Slurred speech
 _____ Learning disabilities
 _____ TOTAL

EMOTIONS

_____ Mood swings
 _____ Anxiety, fear, nervousness
 _____ Anger, irritability, aggressiveness
 _____ Depression
 _____ TOTAL

OTHER

_____ Frequent illness
 _____ Frequent or urgent urination
 _____ Genital itch or discharge
 _____ TOTAL

GRAND TOTAL _____