Symptom picture

Name ……
Date……..

Take time to consider how you have been in the last 30 days and rate each symptom out of ten for how much you have been affected it by it during the last 30 days (eg. Symtom X 5/10). When you do the rating don't think about it too much; go on your gut feeling.

Symptom	**Score**
e.g. Symptom X	5/10
General	
Fatigue	
Sleep disturbance	
Karnofsky Performance Scale	
Weight change	
Fibromyalgia	
Stiffness of the spine	
Body pains	
Postural orthostatic tachycardia Syndrome	
Palpitations	
Light headedness	
Low blood pressure	
High blood pressure	
Hot flushes	
Irritable bowel syndrome	
Discomfort / pain	
Bloating	
Diarrhoea	
Constipation	
Multiple sensitivities	
Foods	
Medications	
Supplements	
Fragrances	
Light	
Sound	
Cognition	
Memory loss	
Brain fog	

Disorientation	
Mental health	
Depression	
Anxiety	
Stress	
Mood swings	
Respiratory	
Shortness of breath	
Wheeze	
Neurological	
Headache	
Blurred vision	
Ringing in the ears	
Skin	
Rash	
Itch	
Immune	
Respiratory infections	
Cold sores	
Genital herpes	
Shingles	
Other infections	
Sexual health	
Lack of libido	
Abnormal arousal / orgasm	
Other symptoms – list below	