SYMPTOM SEVERITY RECORD Patient's Name:_____.

Enter today's date in the first available column at top of grid. List all symptoms you've had in the past few days or last appointment in the column on the left. Please rate them on a scale of 0 to 10, with 10 being the worst.

Symptom List	**Date Completed** (Write in on a slant.)																			
	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Nervous/Anxious																				
Irritable																				
Depressed																				
Suicidal																				
Tearful																				
Fatigue																				
Muscle Weakness																				
Joint Pains																				
Headaches																				
Memory Problems																				
Foggy Thinking																				
Chilly/Cold hands/feet																				
Bowel problems																				
Chemical Sensitivity																				
Electrical Sensitivity																				
Allergy Symptoms																				
Sexual Function prob.																				
Libido problems																				
Hrs of Sleep/night																				
Pain																				
Insomnia																				
Fast heart beat																				
Tired after eating																				
Irrit. by clothing tags																				
Reading problems																				
Sick in stores/malls																				
Sensitive to mold																				
Heat intolerance																				
Exercise intolerance																				
Combative behavior																				