FirstLineTherapy™ Health Profile

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	*Ocasionally* 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
_____ Bloated 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 _____

FirstLine Therapy ™ Health Profile

NAME _____ DATE _____

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

Point Scale				
	0	*Never* or *almost never* have the symptom	3	*Frequently* have it, effec
	1	*Occasionally* have it, effect is *not severe*	4	*Frequently* have it, effec
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HEAD		Headaches
		Faintness
		Dizziness
		Insomnia
	0	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)
	0	TOTAL
EARS		Itchy ears
		Earaches, ear infections
		Drainage from ear
		Ringing in ears, hearing loss
	0	TOTAL
NOSE		Stuffy nose
		Sinus problems
		Hay fever
		Sneezing attacks
		Excessive mucus formation
	0	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
	0	TOTAL
SKIN		Acne
		Hives, rashes, dry skin
		Hair loss
		Flushing, hot flashes
		Excessive sweating
	0	TOTAL
HEART		Irregular or skipped heartbeat
		Rapid or pounding heartbeat
		Chest pain
	0	TOTAL
LUNGS		Chest congestion
		Asthma, bronchitis
		Shortness of breath
		Difficulty breathing

DIGESTIVE TRACT		Nausea, vomiting
		Diarrhea
		Constipation
		Bloated feeling
		Belching, passing gas
		Heartburn
		Intestinal/stomach pain
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JOINTS / MUSCLE		Pain or aches in joints
		Arthritis
		Stiffness or limitation of
		Pain or aches in muscles
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WEIGHT		Binge eating/drinking
		Craving certain foods
		Excessive weight
		Compulsive eating
		Water retention
		Underweight
	0	TOTAL
ENERGY / ACTIVITY		Fatigue, sluggishness
		Apathy, lethargy
		Hyperactivity
		Restlessness
	0	TOTAL
MIND		Poor memory
		Confusion, poor compreh
		Poor concentration
		Poor physical coordinatic
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		Stuttering or stammerin
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	0	TOTAL
EMOTIONS		Mood swings
		Anxiety, fear, nervousnes
		Anger, irritability, aggre
		Depression
	0	TOTAL
OTHER		Frequent illness
		Frequent or urgent urina
		Genital itch or discharge
	0	TOTAL

0 TOTAL **GRAND TOTAL 0**

Past 48 hours

t is *not severe*
t is *severe*

movement

redness

ension

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