Patient's Name: ______________________________ Date: ________________

Please indicate the symptoms you are experiencing as; 0 (none), 1 (mild), 2 (moderate), 3 (severe).
For example, if you are moderately anxious you would indicate this by darkening the 2 next to 'anxious' e.g. 0 1 ■ 3 Anxious

ALL INDIVIDUALS

- 0 1 2 3 Difficulty Concentrating
- 0 1 2 3 Increased Forgetfulness
- 0 1 2 3 Foggy Thinking
- 0 1 2 3 Tearful
- 0 1 2 3 Depressed
- 0 1 2 3 Mood Swings
- 0 1 2 3 Fluid Retention / Bloating
- 0 1 2 3 Cold Extremities
- 0 1 2 3 Stress
- 0 1 2 3 Anxious
- 0 1 2 3 Irritable
- 0 1 2 3 Nervous
- 0 1 2 3 Decreased Mental Sharpness
- 0 1 2 3 Morning Fatigue
- 0 1 2 3 Afternoon Fatigue
- 0 1 2 3 Evening Fatigue

- 0 1 2 3 Excessive Worry
- 0 1 2 3 Difficulty Falling Asleep
- 0 1 2 3 Difficulty Staying Asleep
- 0 1 2 3 Decreased Stamina
- 0 1 2 3 Diminished Motivation
- 0 1 2 3 Fibromyalgia
- 0 1 2 3 Ringing in Ears
- 0 1 2 3 Allergies
- 0 1 2 3 Headaches/Migraines
- 0 1 2 3 Dizzy Spells
- 0 1 2 3 Sugar Cravings
- 0 1 2 3 Addictive Behavior
- 0 1 2 3 Poor Impulse Control
- 0 1 2 3 Obsessive Behavior (OCD)
- 0 1 2 3 Craving Food, Alcohol, Tobacco, or Other

- 0 1 2 3 Constipation
- 0 1 2 3 Goiter
- 0 1 2 3 Cold Body Temperature
- 0 1 2 3 Hoarseness
- 0 1 2 3 Hair Dry or Brittle
- 0 1 2 3 Nails Breaking or Brittle
- 0 1 2 3 Slow Pulse Rate
- 0 1 2 3 Rapid Heartbeat
- 0 1 2 3 Heart Fluttering/Palpitations
- 0 1 2 3 Incontinence
- 0 1 2 3 Hot Flashes
- 0 1 2 3 Night Sweats
- 0 1 2 3 Infertility Problems
- 0 1 2 3 Acne
- 0 1 2 3 Scalp Hair Loss
- 0 1 2 3 Weight Gain-Hips

- 0 1 2 3 Weight Gain-Waist
- 0 1 2 3 High Cholesterol
- 0 1 2 3 Elevated Triglycerides
- 0 1 2 3 Decreased Libido
- 0 1 2 3 Decreased Muscle Size
- 0 1 2 3 Decreased Flexibility
- 0 1 2 3 Burned Out Feeling
- 0 1 2 3 Sore Muscles
- 0 1 2 3 Increased Joint Pain
- 0 1 2 3 Neck or Back Pain
- 0 1 2 3 Bone Loss
- 0 1 2 3 Thinning Skin
- 0 1 2 3 Rapid Aging
- 0 1 2 3 Aches and Pains
- 0 1 2 3 IBS

Height (inches) ________
Weight (lbs) __________

☐ Personal/Family History of: Breast, Uterine, or Ovarian Cancer

WOMEN ONLY

- 0 1 2 3 Vaginal Dryness
- 0 1 2 3 Irregular Periods
- 0 1 2 3 Uterine Fibroids
- 0 1 2 3 Tender Breasts
- 0 1 2 3 Fibrocystic Breasts
- 0 1 2 3 Increased Facial / Body Hair

Last Menses ___/___/______

MEN ONLY

- 0 1 2 3 Decreased Urine Flow
- 0 1 2 3 Increased Urinary Urge
- 0 1 2 3 Prostate Problems
- 0 1 2 3 Decreased Erections

Additional Comments: ____