Breakspear Hospital

Patient Health Status and Symptom Scoring Chart

Name ________________________ **Date of birth** ________ **Patient Ref** ______/__

Please tick the appropriate boxes below

Sex: F ☐ M ☐

Do you smoke? Y ☐ N ☐

How long have you had symptoms? Less than 1 yr ☐ 1-5 years ☐ Over 5 years ☐

Are you suffering from any diagnosed non-allergy related illness? Y ☐ N ☐

If Yes, which?

Are you, or have you in the past 3 months, been taking any drugs, prescribed or not? Y ☐ N ☐

If Yes, which?

Have you been treated with provocation/neutralisation before? Y ☐ N ☐

This is my 1st Symptom Scoring Chart ☐
This is a follow-up Symptom Scoring Chart ☐

Please give a score for each symptom below according to the following scale

0 – never or almost never have symptoms
1 – occasionally have, effect not severe
2 – occasionally have, effect severe
3 – frequently have, effect not severe
4 – frequently have, effect severe

SKIN	
Eczema or dry skin	
Hives or itchy rashes	
Tingling sensation	
Hair loss	
Hot flushes	
Excessive sweating	
TOTAL	

EYES	
Watery eyes	
Red or itchy eyes	
Swollen or sticky eyelids	
Bags or dark rings under eyes	
Blurred vision	
Impaired vision	
TOTAL	

HEART & LUNGS	
Heart palpitations	
Rapid or pounding heart	
Chest pain	
Chest congestion	
Breathlessness	
Coughing or sneezing	
TOTAL	

NOSE	
Stuffy nose	
Sinus problems	
Sneezing attacks	
Hayfever	
Runny nose	
Excessive mucus or catarrh	
TOTAL	

DIGESTIVE TRACT	
Nausea or vomiting	
Diarrhoea	
Constipation	
Stomach bloating or cramp	
Belching/wind	
Heartburn or similar pain	
TOTAL	

HEAD	
Headache or migraine	
Faintness	
Dizziness	
Loss of balance	
'Voices' in head	
Remote feeling	
TOTAL	

continued over . . . .

MOUTH & THROAT	
Gagging, constant need to clear throat	
Sore or red throat	
Swollen or discoloured lips, gums or tongue	
Cold sores	
Mouth ulcers	
Hoarseness or loss of voice	
TOTAL	

ENERGY/ACTIVITY	
Apathy	
Hyperactivity	
Fatigue or lethargy	
Restlessness	
Insomnia	
Clumsiness	
TOTAL	

EARS	
Itching ears	
Earache or infection	
Discharge from ear	
Ringing in ears	
Hearing loss	
Popping ears	
TOTAL	

JOINTS & MUSCLES	
Aching/painful joints	
Aching/painful muscles	
Stiffness	
Arthritis	
Gout	
Weakness	
TOTAL	

WEIGHT	
Binge eating or drinking	
Craving certain foods	
Compulsive eating	
Water retention	
Excessive weight	
Underweight	
TOTAL	

MIND	
Poor memory	
Confusion or indecisiveness	
Poor concentration	
Stuttering or stammering	
Slurred speech	
Poor physical co-ordination	
TOTAL	

EMOTIONS	
Elation	
Mood swings	
Anxiety, panic or fear	
Irritability	
Anger or aggression	
Depression	
TOTAL	
SUB TOTAL	

OTHER	
Frequent illness/viruses/infections	
Frequent or urgent urination	
Genital itch or discharge	
Thrush or athlete's foot	
Problems using electrical equipment	
Problems with teeth	
TOTAL	
SUB TOTAL	

GRAND TOTAL ☐

For follow-up patients only, please tick the appropriate boxes below

Which of the following conditions have been diagnosed at Breakspear Hospital?	
Allergy or sensitivity to foods	
Allergy or sensitivity to chemicals	
Sensitivity to light or electric impulses	
ME or Chronic Fatigue Syndrome	
Other	

Which of the following treatments have you received at Breakspear Hospital?	
Provocation/neutralisation	
Supplementation with vitamins & minerals	
Chelation Therapy	
Other	

Date ______________________________