



# Patient health status and symptom scoring chart

Date \_\_\_\_\_ Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**Please tick the appropriate boxes below**

Sex	<table border="1"><tr><td>F</td><td></td></tr><tr><td>M</td><td></td></tr></table>	F		M		Do you smoke?	<table border="1"><tr><td>Y</td><td></td></tr><tr><td>N</td><td></td></tr></table>	Y		N		How long have you had symptoms?	Less than 1 year	<table border="1"><tr><td></td></tr></table>	
F															
M															
Y															
N															
					1-5 years	<table border="1"><tr><td></td></tr></table>									
					Over 5 years	<table border="1"><tr><td></td></tr></table>									

Are you suffering from any diagnosed illness which is not allergy-related?	<table border="1"><tr><td>Y</td><td></td></tr><tr><td>N</td><td></td></tr></table>	Y		N		Are you, or have you in the past 3 months been, taking any prescribed or non-prescribed drugs?	<table border="1"><tr><td>Y</td><td></td></tr><tr><td>N</td><td></td></tr></table>	Y		N	
Y											
N											
Y											
N											

If yes, which? \_\_\_\_\_  
\_\_\_\_\_

If yes, which? \_\_\_\_\_  
\_\_\_\_\_

Have you been treated with low-dose immunotherapy before?	<table border="1"><tr><td>Y</td><td></td></tr><tr><td>N</td><td></td></tr></table>	Y		N	
Y					
N					

This is my 1 <sup>st</sup> symptom scoring chart	<table border="1"><tr><td></td></tr></table>	
This is a follow-up symptom scoring chart	<table border="1"><tr><td></td></tr></table>	

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

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

**SKIN**

Eczema or dry skin	<table border="1"><tr><td></td></tr></table>	
Hives or itchy rashes	<table border="1"><tr><td></td></tr></table>	
Tingling sensation	<table border="1"><tr><td></td></tr></table>	
Hair loss	<table border="1"><tr><td></td></tr></table>	
Hot flushes	<table border="1"><tr><td></td></tr></table>	
Excessive sweating	<table border="1"><tr><td></td></tr></table>	
<b>TOTAL</b>	<table border="1"><tr><td></td></tr></table>	

**EYES**

Watery eyes	<table border="1"><tr><td></td></tr></table>	
Red or itchy eyes	<table border="1"><tr><td></td></tr></table>	
Swollen or sticky eyelids	<table border="1"><tr><td></td></tr></table>	
Bags or dark rings under eyes	<table border="1"><tr><td></td></tr></table>	
Blurred vision	<table border="1"><tr><td></td></tr></table>	
Impaired vision	<table border="1"><tr><td></td></tr></table>	
<b>TOTAL</b>	<table border="1"><tr><td></td></tr></table>	

**HEART & LUNGS**

Heart palpitations	<table border="1"><tr><td></td></tr></table>	
Rapid or pounding heart	<table border="1"><tr><td></td></tr></table>	
Chest pain	<table border="1"><tr><td></td></tr></table>	
Chest congestion	<table border="1"><tr><td></td></tr></table>	
Breathlessness	<table border="1"><tr><td></td></tr></table>	
Coughing or sneezing	<table border="1"><tr><td></td></tr></table>	
<b>TOTAL</b>	<table border="1"><tr><td></td></tr></table>	

**NOSE**

Stuffy nose	<table border="1"><tr><td></td></tr></table>	
Sinus problems	<table border="1"><tr><td></td></tr></table>	
Sneezing attacks	<table border="1"><tr><td></td></tr></table>	
Hayfever	<table border="1"><tr><td></td></tr></table>	
Runny nose	<table border="1"><tr><td></td></tr></table>	
Excessive mucus or catarrh	<table border="1"><tr><td></td></tr></table>	
<b>TOTAL</b>	<table border="1"><tr><td></td></tr></table>	

**DIGESTIVE TRACT**

Nausea or vomiting	<table border="1"><tr><td></td></tr></table>	
Diarrhoea	<table border="1"><tr><td></td></tr></table>	
Constipation	<table border="1"><tr><td></td></tr></table>	
Stomach bloating or cramp	<table border="1"><tr><td></td></tr></table>	
Belching/wind	<table border="1"><tr><td></td></tr></table>	
Heartburn or similar pain	<table border="1"><tr><td></td></tr></table>	
<b>TOTAL</b>	<table border="1"><tr><td></td></tr></table>	

**HEAD**

Headache or migraine	<table border="1"><tr><td></td></tr></table>	
Faintness	<table border="1"><tr><td></td></tr></table>	
Dizziness	<table border="1"><tr><td></td></tr></table>	
Loss of balance	<table border="1"><tr><td></td></tr></table>	
'Voices' in head	<table border="1"><tr><td></td></tr></table>	
Remote feeling	<table border="1"><tr><td></td></tr></table>	
<b>TOTAL</b>	<table border="1"><tr><td></td></tr></table>	

Date \_\_\_\_\_ Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**MOUTH & THROAT**

Gagging, constant need to clear throat	<input type="checkbox"/>
Sore or inflamed throat	<input type="checkbox"/>
Swollen or discoloured lips, gums or tongue	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>
Mouth ulcers	<input type="checkbox"/>
Hoarseness or loss of voice	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

**ENERGY/ACTIVITY**

Apathy	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>
Fatigue or lethargy	<input type="checkbox"/>
Restlessness	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>
Clumsiness	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

**EARS**

Itching ears	<input type="checkbox"/>
Earache or infection	<input type="checkbox"/>
Discharge from ears	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>
Popping ears	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

**JOINTS & MUSCLES**

Aching/painful joints	<input type="checkbox"/>
Aching/painful muscles	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>
Gout	<input type="checkbox"/>
Weakness	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

**WEIGHT**

Binge eating or drinking	<input type="checkbox"/>
Craving certain foods	<input type="checkbox"/>
Compulsive eating	<input type="checkbox"/>
Water retention	<input type="checkbox"/>
Excessive weight	<input type="checkbox"/>
Underweight	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

**MIND**

Poor memory	<input type="checkbox"/>
Confusion or indecisiveness	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>
Stuttering or stammering	<input type="checkbox"/>
Slurred speech	<input type="checkbox"/>
Poor physical co-ordination	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

**EMOTIONS**

Elation	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>
Anxiety, panic or fear	<input type="checkbox"/>
Irritability	<input type="checkbox"/>
Anger or aggression	<input type="checkbox"/>
Depression	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

**OTHER**

Frequent illness/viruses/infections	<input type="checkbox"/>
Frequent or urgent urination	<input type="checkbox"/>
Genital itch or discharge	<input type="checkbox"/>
Thrush or athlete's foot	<input type="checkbox"/>
Sensitivity to electrical equipment	<input type="checkbox"/>
Problems with teeth	<input type="checkbox"/>
<b>TOTAL</b>	<input type="checkbox"/>

SUB 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?**

Allergy or sensitivity to foods	<input type="checkbox"/>
Allergy or sensitivity to chemicals	<input type="checkbox"/>
Sensitivity to light or electric impulses	<input type="checkbox"/>
ME or Chronic Fatigue Syndrome	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

**Which of the following treatments have you received at Breakspear?**

Low-dose immunotherapy	<input type="checkbox"/>
Supplementation with vitamins & minerals	<input type="checkbox"/>
Chelation therapy	<input type="checkbox"/>
Other _____	<input type="checkbox"/>