Patient Label

CMB Health Specialties

Date:_____

# My Health Assessment for Today's Office Visit

Rate each of the following symptoms based on your typical health profile over the last month.

**POINT SCALE:**

0 = *Never* or *almost never* have the symptom
1 = Occasionally have it, effect is *not severe*
2 = Occasionally have it, effect is *severe*
3 = Frequently have it, effect is *not severe*
4 = Frequently have it, effect is *severe*

ORIGINAL SCORE_____

**GENERAL ENERGY**
___ Fatigue, sluggishness
___ Tires easily
___ Lack of Interest
___ Hyperactivity
___ Restlessness Total
___ Other:_____

**HEAD**
___ Headaches
___ Faintness/Lightheadedness
___ Dizziness Total
___ Other:_____

**MIND/EMOTIONS**
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Anxiety, fear or nervousness
___ Irritability/Anger
___ Depression Total
___ Other:_____

**HORMONE**
___ Lack of endurance
___ Difficulty sleeping
___ Mood swings
___ Flushing or hot flashes
___ Night sweats Total
___ Other:_____

**EYES, EARS, NOSE, THROAT**
___ Change in vision
___ Watery or itchy eyes
___ Swollen, tender or sticky eyelids
___ Puffiness under eyes
___ Blurred vision
___ Itchy ears
___ Earaches, ear infection
___ Ringing in ears, hearing loss
___ Stuffy nose/Sneezing
___ Sinus problems
___ Sore throat, hoarseness
___ Swollen or painful tongue
___ Canker sores Total
___ Other:_____

**LUNGS/CHEST**
___ Cough
___ Chest congestions
___ Asthma, bronchitis
___ Trouble breathing Total
___ Other:_____

**HEART**
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain Total
___ Other:_____

**PELVIC**
___ Frequent or urgent urination
___ Genital itch or discharge
___ Pain Total
___ Other:_____

**DIGESTION**
___ Nausea or vomiting
___ Heartburn
___ Bloated feeling
___ Belching or passing gas
___ Constipation
___ Diarrhea
___ Abdominal Pain Total
___ Other:_____

**SKIN**
___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Fingernail abnormalities
___ Other:_____

**MUSCULOSKELETAL**
___ Back pain
___ Pain or aches in joints
___ Cramps in legs/hands Total
___ Other:_____

**WEIGHT**
___ Binge eating/drinking
___ Craving certain foods_____
___ Overweight
___ Underweight
___ Compulsive eating
___ Water retention Total
___ Other:_____

**RECENT INJURY** Total
_____

**TODAY'S TOTAL**

New symptoms/concerns:_____
_____
_____
_____
_____
_____
_____

Signature:_____