HILL COUNTRY INTENTIONAL HEALING

DATE: _____

MEDICAL SYMPTOMS QUESTIONNAIRE

Name: _____

Rate each of the following symptoms based upon your typical health profile for:
Past 30 days Past 48 hours, if applicable

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*

	Past 48 Hours *if applicable*	Past 30 Days		
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	
	_____	_____	Drainage from ear	
	_____	_____	Ringing in ears, hearing loss	
				TOTAL _____
NOSE	_____	_____	Stuffy Nose	
	_____	_____	Sinus Problems	
	_____	_____	Hay Fever	
	_____	_____	Sneezing Attacks	
	_____	_____	Excessive mucus formation	
				TOTAL _____
MOUTH/	_____	_____	Chronic coughing	
THROAT	_____	_____	Gagging, frequent need to clear throat	
	_____	_____	Sore throat, hoarseness, loss of voice	
	_____	_____	Swollen or discolored tongue, gums, 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 _____

Hill Country Intentional Healing

	Past 48 Hours *if applicable*	Past 30 Days		
LUNGS	_____	_____	Chest congestion	
	_____	_____	Asthma, bronchitis	
	_____	_____	Shortness of breath	
	_____	_____	Difficulty breathing	
				TOTAL _____
DIGESTIVE TRACT	_____	_____	Nausea, vomitting	
	_____	_____	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 making decisions	
	_____	_____	Stuttering or stammering	
	_____	_____	Slurred speech	
	_____	_____	Learning Disabilities	
				TOTAL _____
EMOTIONS Circle what applies to you	_____	_____	Mood swings	
	_____	_____	Anxiety, fear, nervousness	
	_____	_____	Anger, irritability, aggressiveness	
	_____	_____	Depression	
				TOTAL _____
OTHER	_____	_____	Frequent Illness	
	_____	_____	Frequent or urgent urination	
	_____	_____	Genital itch or discharge	
				TOTAL _____
				GRAND TOTAL _____