## Symptom Checklist

Name:_____ Date:_____

Please check any of the following symptoms you experience frequently or have a tendency towards.

___Fatigue/Low Energy
___Bruise easily
___Tired after eating
___Low appetite
___Strong appetite
___Loose stools
___Constipation
___Abdominal bloating
___Heartburn/Reflux
___Post Nasal Drip
___Nausea/Vomiting
___Frequent hiccups or belching
___Flatulence
___Hemorrhoids
___Excessive vaginal discharge
___Bad breath
___Tendency to worry/obsess
___Stomach ulcers
___Mouth sores
___Bleeding gums

___Recurrent colds/Infections
___Sinus problems
___Allergies
___Sweat easily
___Do not sweat
___Blood or mucus in stool
___Pain in the teeth or gums
___Skin problems
___Shortness of breath
___People often ask you to speak up
___Feel Sad

___Difficulty sleeping
___Heart palpitations
___Anxiety
___Memory problems
___Sores on the tongue
___Startle easily
___Laugh inappropriately

___Frequent irritability/Frustration
___Depression/Tendency to feel sad
___Frequent sighing
___Abdominal pain
___Pain under the ribcage
___Floaters
___Can't see well at night
___Red eyes
___Wake between 1-3am
___Trouble falling asleep
___Dizziness
___Tight muscles
___Painful periods
___Irregular periods
___Inability to cry
___Headaches/Migraines

___Low back pain
___Frequent urination
___Knee pain
___Low sex drive
___High sex drive
___Erectile dysfunction
___Night sweats
___Hot flashes
___Poor hearing
___Ringing in ear
___Wear socks to bed
___Vaginal dryness
___Congentital abnormalities

Other symptoms not listed:

InsideOut
BODY THERAPIES