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Initial Symptom Survey			
Date:	Patient Name:	Dietitian:	
<b>INSTRUCTIONS:</b> Score every symptom based on your experience <b>OVER THE PAST MONTH</b> . Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed. Note score in the boxes to the left of symptoms. Also note the number of missed work days in the last month due to illness.			
<b>SCALE OF SYMPTOM POINTS</b> <b>IF you did not suffer from the symptom ever or almost never, leave it blank.</b> 1 = <b>OCCASIONALLY</b> (less than 2 times per week), and symptom <b>was MILD</b> 2 = <b>FREQUENTLY</b> (2 or more times per week), and symptom <b>was MILD</b> 3 = <b>OCCASIONALLY</b> (less than 2 times per week), and symptom <b>was SEVERE</b> 4 = <b>FREQUENTLY</b> (2 or more times per week), and symptom <b>was SEVERE</b>			<b>Grand Total:</b>  
			<b># Missed Work Days</b>  
<b>CONSTITUTIONAL</b> Fatigue (sluggish, tired) Hyperactive (nervous energy) Restless (can't relax/sit still) Daytime sleepiness Insomnia at night Malaise (feeling lousy) Seizures <b>TOTAL (0-28)</b>		<b>NASAL/SINUS</b> Post nasal drip Sinus pain Runny nose Stuffy nose Sneezing <b>TOTAL (0-20)</b> <b>MOUTH/THROAT</b> Sore throat Swollen throat Swelling/burning lips/tongue Gagging/throat clearing Canker sores Difficulty swallowing <b>TOTAL (0-24)</b> <b>LUNGS</b> Wheezing Chest congestion Dry cough Wet cough Shortness of breath <b>TOTAL (0-20)</b> <b>EYES</b> Red or swollen eyes Watery eyes Itchy eyes Dark circles or "bags" Sensitivity to light Aura (all types) <b>TOTAL (0-24)</b> <b>GENITOURINARY</b> Increased urinary frequency Painful urination Bladder pain Bedwetting <b>TOTAL (0-16)</b>	
<b>EMOTIONAL/MENTAL</b> Depression Anxiety (fears, uneasiness) Mood swings (rapid changes) Irritability Forgetfulness Lack of concentration/Brain fog Low sex drive <b>TOTAL (0-28)</b> <b>HEAD/EARS</b> Headache (not migraine) Migraine Earache Ear infection Ringing in ears Itchy ears Discharge from ears Sensitivity to sound <b>TOTAL (0-32)</b> <b>SKIN</b> Blemishes, acne Rashes or hives Eczema or psoriasis "Rosy" cheeks Flushing Itchy skin <b>TOTAL (0-24)</b>		<b>MUSCULOSKELETAL</b> Joint pains Stiff joints Muscle aches Stiff muscles Ticks (facial or otherwise) Muscle spasms Muscle cramps <b>TOTAL (0-28)</b> <b>CARDIOVASCULAR</b> Irregular heartbeat High blood pressure <b>TOTAL (0-8)</b> <b>DIGESTIVE</b> Heartburn/reflux Stomach pains/cramps Intestinal pains/cramps Constipation Diarrhea Bloating sensation Gas (of any kind) Nausea Vomiting Painful elimination <b>TOTAL (0-40)</b> <b>WEIGHT MANAGEMENT</b> Current weight: Fluctuating weight Food cravings Water retention Binge eating or drinking Purging (all methods) <b>TOTAL (0-20)</b> <b>LIST OTHER SYMPTOMS:</b> 	

Adapted by Carolyn Dolan PT, DPT, Cert MDT, MSHN from the original work of Meg Mangano RD at ReJoov wellness. Reprinted with Permission. Updated 05/16/2015