603-B W. Patrick St Frederick MD 21701 301-620-1414

Revisit Form

Name:____ Date:_____________

What positive changes have you noticed since your last appointment?: __________________________________
____
____

What are your main concerns at this time?:____
____
____

Any changes with weight or waist size?:_________ How is sleep:_______________________________

Constipation or diarrhea or bloating:?___________ How is your mood:__________________________

Are you cooking more: _______________________ Is your energy higher or lower:________________

What foods do you crave? What are you doing / feeling when you crave?:_____________________________
____

What's your diet like these days? Skip this question if you are keeping a food journal. ____________________
____

Breakfast	Lunch	Dinner	Snacks	Liquids
___________	___________	___________	___________	___________
___________	___________	___________	___________	___________
___________	___________	___________	___________	___________
___________	___________	___________	___________	___________
___________	___________	___________	___________	___________
___________	___________	___________	___________	___________
___________	___________	___________	___________	___________

Any other comments: ____
____
____

HOLISTIC HEALTH ASSOCIATES

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Symptom Questionnaire Revisit

Initials:____________ **Number # :** ____________ **Visit # :** ____________ **Date:** ____________

Rate each of the following symptoms based on the last **2 weeks**:

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

Head ____Headaches ____ Faintness ____Dizziness ____Insomnia ____Total	Digestive Tract ____Nausea, vomiting ____Diarrhea ____Constipation ____Bloated feeling ____ Belching, passing gas ____Heartburn ____Intestinal / stomach pain ____Total
Eyes ____Watery or itchy eyes ____ Swollen, red or sticky eyelids ____Bags or dark circles under eyes ____ Blurred or tunnel vision (does not include near or farsightedness) ____Total	Joints/ Muscle ____Pain or aches in joints ____Arthritis ____ Stiff or limitation of movement ____ Pain or aches in muscles ____ Feeling of weakness or tired ____Total
Ears ____ Itchy ears ____ Earaches, ear infections ____ Drainage from ear ____ Ringing in ears, hearing loss ____Total	Weight ____Binge eating/drinking ____Craving certain foods ____Excessive weight ____Compulsive eating ____Water retention ____ Underweight ____Total
Nose ____ Stuffy Nose ____ Sinus problems ____ Hay fever ____ Sneezing attacks ____ Excessive mucus formation ____Total	Energy/ Activity ____Fatigue, sluggishness ____ Apathy, lethargy ____Hyperactivity ____ Restlessness ____Total
Mouth/ Throat ____Chronic Coughing ____Gagging / need to clear throat ____Sore throat, hoarse, loss of voice ____Swollen or discolored tongue, gums, or lips ____Canker sores ____Total	Mind ____Poor memory ____ Confusion, poor comprehension ____Poor concentration ____ Poor physical coordination ____Difficulty in making decisions ____ Stuttering or stammering ____ Slurred speech ____ Learning disabilities ____Total
Skin ____Acne ____Hives, rashes, dry skin ____Hair loss ____Flushing, hot flashes ____Excessive sweating ____Total	Emotions ____ Mood swings ____Anxiety, fear, nervousness ____ Anger, irritability, aggression ____ Depression ____Total
Heart ____Irregular or skipped heartbeat ____Rapid or pounding heartbeat ____ Chest pain ____Total	Other ____Frequent illness ____Frequent or urgent urination ____Genital itch or discharge ____Total
Lungs ____Chest congestion ____Asthma, bronchitis ____Shortness of breath ____Difficulty breathing ____Total	Grand Total __________________