Name_____Date_____

Top 3 Complaints

1._____

2._____

3._____

Diagnosis from Medical Doctors_____

Head/Neck Symptoms

___Ringing in the ears
___Brain Fog
___Memory Loss
___Blurry Vision
___Speech Difficulty
___Facial Paralysis
___Migraines
___Dizziness
___Inability to focus
___Hair loss

Muscular/Joint Symptoms

___Impaired Coordination
___Weakness
___Muscle Cramping
___Muscle Twitching
___Joint Pain
___Burning sensation

Gastrointestinal Symptoms

___Acid Relux
___Constipation
___Loose stools
___Loss of appetite
___Excess Gas

Psychiatric/Emotions

___Depression
___Anxiety
___Short fuse
___Overlly Emotional

Sleep

___Can't get to sleep
___Can't stay asleep
___Both
___Chronic Fatigue

Hormones (females)

___Periods heavy
___Periods not 28 days
___Absent periods
___Infertility
___Ovulation problems
___History of miscarriage

Other:_____