

FirstLineTherapy® Health Profile

NAME _____

DATE _____

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

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 _____

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, ear infections
Drainage from ear
Ringing in ears, hearing loss
TOTAL _____

NOSE

Stuffy nose
Sinus problems
Hay fever
Sneezing attacks
Excessive mucus formation
TOTAL _____

**MOUTH/
THROAT**

Chronic coughing
Gagging, frequent need to clear throat
Sore throat, hoarseness, loss of voice
Swollen or discolored tongue, gums or 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 _____

LUNGS

Chest congestion
Asthma, bronchitis
Shortness of breath
Difficulty breathing
TOTAL _____

**DIGESTIVE
TRACT**

Nausea, vomiting
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 in making decisions
Stuttering or stammering
Slurred speech
Learning disabilities
TOTAL _____

EMOTIONS

Mood swings
Anxiety, fear, nervousness
Anger, irritability, aggressiveness
Depression
TOTAL _____

OTHER

Frequent illness
Frequent or urgent urination
Genital itch or discharge
TOTAL _____

GRAND TOTAL _____