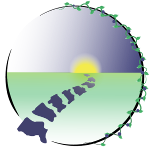

Pathway to Wellness

Symptom Tracker

Name ________________________ Date ________________________

0 = None **1** = Some **2** = Mild **3** = Moderate **4** = Severe **Grand Total** __________

HEAD TOTAL_______	MIND TOTAL ______	EYES TOTAL ______
____ Headaches ____ Faintness ____ Migraines ____ Dizziness ____ Trouble Sleeping	____ Brain Fog ____ Impaired Coordination ____ Difficulty Deciding ____ Slurred/Stuttered Speech ____ Learning Attention Deficit ____ Poor Memory	____ Swollen, Red Eyes ____ Dark Circles ____ Puffy Eyes ____ Poor Vision ____ Watery, Itchy Eyes
NOSE TOTAL_______	**EARS TOTAL_______**	**MOUTH/ THROAT TOTAL_______**
____ Nasal Congestion ____ Excessive Mucous ____ Stuffy/Runny Nose ____ Sinus Problems ____ Frequent Sneezing	____ Itchy Ears ____ Earaches/Infections ____ Drainage From Ear ____ Ringing, Hearing Loss	____ Chronic Cough ____ Clear Throat Frequently ____ Sore Throat ____ Swollen Lips ____ Canker Sores
HEART TOTAL_______	**LUNGS TOTAL_______**	**SKIN TOTAL_______**
____ Irregular Heartbeat ____ Fast Heart Rate ____ Chest Pain	____ Chest Congestion ____ Asthma, Bronchitis ____ Shortness of breath ____ Difficulty Breathing	____ Acne ____ Hives, Eczema, Hair Loss ____ Hair Loss ____ Hot Flashes ____ Excessive Sweating
Weight TOTAL_______	**Digestion TOTAL_______**	**Emotions TOTAL_______**
____ Overweight ____ Food Cravings ____ Inability to lose weight ____ Water Retention/Swelling ____ Compulsive Eating ____ Underweight	____ Nausea/Vomiting ____ Constipation ____ Heartburn/Indigestion ____ Belching/Passing Gas ____ Intestinal/Stomach pain or cramping ____ Diarrhea ____ Bloating	____ Anxiety ____ Depression ____ Mood Swings ____ Nervousness ____ Easily Irritated
Energy Level TOTAL_______	**Joint/Muscles TOTAL_______**	**Other TOTAL_______**
____ Fatigue ____ Lethargy ____ Hyperactivity ____ Restlessness	____ Pain/Aching Joints ____ Muscle Stiffness ____ Pain/Muscle Aches ____Weakness/Tiredness ____ Arthritis	____ Frequent Illness/Infections ____ Frequent Urgent Urination ____ Genital Itch/Discharge ____Menstrual Issues-Specify: __________________________