SYMPTOM TRACKER

The Nourishing Place **Carol Bennett RD, CCN**

Name:___________________ **Date:______________**

HEAD	MIND	EYES
___headaches ___migraines ___faintness ___trouble sleeping **TOTAL___**	___brain fog ___poor memory ___difficulty deciding ___slurred/stuttered speech ___learning/attention deficit **TOTAL___**	___swollen, red eyelids ___dark circles ___puffy eyes ___poor vision ___watery, itchy eyes **TOTAL___**
NOSE	**SKIN**	**MOUTH/THROAT**
___nasal congestion ___excessive mucus ___stuffy/runny nose ___sinus problems ___frequent sneezing **TOTAL___**	___acne ___hives ___eczema, dry skin ___hair loss ___hot flashes ___excessive sweating **TOTAL___**	___chronic cough ___clear throat frequently ___sore throat ___swollen lips ___canker sores ___cracking corners mouth **TOTAL___**
HEART	**LUNGS**	**EARS**
___irregular heartbeat ___fast heart rate ___chest pain **TOTAL___**	___chest, congestion ___asthma, bronchitis ___shortness of breath ___difficult breathing **TOTAL___**	___itchy ears ___earaches, infections ___drainage from ear ___ringing, hearing loss **TOTAL___**
WEIGHT	**DIGESTION**	**EMOTIONS**
___inability to lose weight ___food cravings ___overweight ___underweight ___compulsive eating ___water retention/swelling **TOTAL___**	___nausea/vomiting ___diarrhea ___constipation ___bloating ___belching/passing gas ___heartburn/indigestion ___intestinal/stomach pain or cramps **TOTAL___**	___anxiety ___depression ___mood swings ___nervousness ___easily frustrated **TOTAL___**
ENERGY/ACTIVITY	**JOINTS/MUSCLES**	**OTHER**
___fatigue ___lethargy ___hyperactivity ___restlessness **TOTAL___**	___pain/aching joints ___arthritis ___muscle stiffness ___pain/muscle aches ___weakness/tiredness **TOTAL___**	___frequent illness/infections ___frequent/urgent urination ___genital itch, discharge ___anal itch **TOTAL___**

Check the symptoms which pertain to you, and total.

GRAND TOTAL_________