

# FirstLine Therapy™ HEALTH PROFILE

NAME \_\_\_\_\_ DATE \_\_\_\_\_ E-MAIL \_\_\_\_\_

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

<b>Point Scale</b>	<b>0</b> Never or almost never have the symptom <b>1</b> Occasionally have it, effect is <i>not</i> severe <b>2</b> Occasionally have it, effect is severe	<b>3</b> Frequently have it, effect is <i>not</i> severe <b>4</b> Frequently have it, effect severe
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**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

**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  
 \_\_\_\_\_ Bbloated 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** \_\_\_\_\_