Abundant Life Nutrition and Health

HEALTH PROFILE

Name: ______________________ Date: ______________ Week: ________

Rate each of the following symptoms, based upon your typical health profile over the past 30 days, using the following scale:

0 = **Never or almost never** have the symptom
1 = **Occasionally** have it, effect is **not severe**
2 = **Occasionally** have it, effect is **severe**
3 = **Frequently** have it, effect is **not severe**
4 = **Frequently** have it, effect is **severe**

Category	Score	Symptom	Category	Score	Symptom
HEAD	_______	Headache	**EARS**	_______	Itchy ears
	_______	Faintness		_______	Earaches, ear infections
	_______	Dizziness		_______	Drainage from ear
	_______	Insomnia		_______	Ringing in ears, hearing loss
	_______	**TOTAL**		_______	**TOTAL**
EYES	_______	Watery or itchy eyes	**NOSE**	_______	Stuffy nose
	_______	Swollen, reddened or sticky eyelids		_______	Sinus problems
	_______	Bags or dark circles under eyes		_______	Hay fever
	_______	Blurred or tunnel vision (does not include near-sightedness or far-sightedness)		_______	Sneezing attacks
				_______	Excessive mucus formation
	_______	**TOTAL**		_______	**TOTAL**
MOUTH/ THROAT	_______	Chronic coughing	**SKIN**	_______	Acne
	_______	Gagging, frequent need to clear throat		_______	Hives, rashes, dry skin
	_______	Sore throat, hoarseness, loss of voice		_______	Hair loss
	_______	Swollen or discolored tongue, gums, or lips		_______	Flushing, hot flashes
	_______	Canker sores		_______	Excessive sweating
	_______	**TOTAL**		_______	**TOTAL**
HEART	_______	Irregular or skipped heartbeat	**LUNGS**	_______	Chest congestion
	_______	Rapid or pounding heartbeat		_______	Asthma, bronchitis
	_______	Chest pain		_______	Shortness of breath
				_______	Difficulty breathing
	_______	**TOTAL**		_______	**TOTAL**
DIGESTIVE TRACT	_______	Nausea, vomiting	**JOINTS / MUSCLES**	_______	Pain or aches in joints
	_______	Diarrhea		_______	Arthritis
	_______	Constipation		_______	Stiffness or limitation of movement
	_______	Bloated feeling		_______	Pain or aches in muscles
	_______	Belching, passing gas		_______	Feeling of weakness or tiredness
	_______	Heartburn			
	_______	Intestinal/stomach pain			
	_______	**TOTAL**		_______	**TOTAL**
WEIGHT	_______	Binge eating / drinking	**MIND**	_______	Poor memory
	_______	Craving certain foods		_______	Confusion, poor comprehension
	_______	Excessive weight gain		_______	Poor concentration
	_______	Compulsive eating		_______	Poor physical coordination
	_______	Water retention		_______	Difficulty in making decisions
	_______	Underweight		_______	Stuttering or stammering
				_______	Slurred speech
				_______	Learning disabilities
	_______	**TOTAL**		_______	**TOTAL**
ENERGY / ACTIVITY	_______	Fatigue, sluggishness	**EMOTIONS**	_______	Mood swings
	_______	Apathy, lethargy		_______	Anxiety, fear, nervousness
	_______	Hyperactivity		_______	Anger, irritability, aggressiveness
	_______	Restlessness		_______	Depression
	_______	**TOTAL**		_______	**TOTAL**
OTHER	_______	Frequent illness			
	_______	Frequent or urgent urination			
	_______	Genital itch or discharge		_______	**GRAND TOTAL**
	_______	**TOTAL**			