WEEKLY SYMPTOM CHECKLIST FOR CHILDREN

Name_____ Date_____

Rate each of the following symptoms based on your child's current health profile

Point Scale

0 - *Never* or *almost never* has the symptom
1 - *Occasionally* has symptoms
2 - *Frequently* has symptoms

HEAD	_____	Headaches	
	_____	Difficulty falling asleep	
	_____	Wakes up during the night	Total _____
EYES	_____	Watery or itchy eyes	
	_____	Dark circles under eyes	
	_____	Bags under eyes	
	_____	Swollen eyelids	Total _____
EARS	_____	Reddening of ears	
	_____	Itchy ears	
	_____	Earaches/Ear infections (circle which apply)	
	_____	Drainage from ear	
	_____	Hearing loss	
	_____	Frequent pulling on ears	Total _____
NOSE	_____	Runny nose	
	_____	Stuffy nose	
	_____	Sneezing	
	_____	"Allergic Salute" (rubs, itches, wipes nose frequently with hands)	Total _____
MOUTH/THROAT	_____	Swollen or red lips	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or sore or discolored tongue	
	_____	Swollen or sore gums or lips	
	_____	Canker sores	Total _____
SKIN	_____	Easy bruising	
	_____	Hives	
	_____	Rash	
	_____	Dry or flaky skin	
	_____	Flushing	
	_____	Cold hands or feet	
	_____	Eczema	Total _____
LUNGS	_____	Coughing	
	_____	Sneezing	
	_____	Difficulty breathing	
	_____	Wheezing	Total _____

DIGESTIVE TRACT	_____	Nausea	
	_____	Vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching	
	_____	Passing gas (flatulence)	
	_____	Heartburn	
	_____	Tummy ache	
	_____	Poor appetite	
	_____	Refusal to eat	Total _____
JOINTS/MUSCLE	_____	Coordination problems	
	_____	Pain in muscles (e.g., leg ache)	
	_____	Pain in joints (e.g., knee ache)	Total _____
ENERGY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	
	_____	Sleeping problems	Total _____
MIND/EMOTIONS	_____	Inattentiveness or poor concentration	
	_____	Mood swings	
	_____	Anxiety, nervousness	
	_____	Fear	
	_____	Anger	
	_____	Irritability	
	_____	Aggressiveness (e.g. hitting, kicking, biting)	
	_____	Crying or weepiness	
	_____	Tantrums	
	_____	Hyperactivity	Total _____
OTHER	_____	Frequent urination	
	_____	Itching of anus or genitals	
	_____	Bed wetting	
	_____	Wetting or soiling of clothes	
			Total _____

GRAND TOTAL **TOTAL: _____**