SYMPTOM WORKSHEET

PATIENT INFORMATION		
Name: ____________	Date of Birth: ____________	Gender: ☐ Male ☐ Female
Height: ____________ Weight: ____________	Activity Level: ☐ None ☐ Light ☐ Moderate ☐ Frequent ☐ Heavy	

Have you experienced any of the following in the last 14 days?

Symptom	Yes	No	FOR OFFICE USE ONLY: ANS	FOR OFFICE USE ONLY: Vascular
Frequent Urination	☐ Yes	☐ No		
Nausea	☐ Yes	☐ No		
Numbness in Hands & Feet	☐ Yes	☐ No		
Vomiting	☐ Yes	☐ No		
Burning Sensation	☐ Yes	☐ No		
Difficulty Digesting Food	☐ Yes	☐ No		
Sweat Abnormalities	☐ Yes	☐ No		
Sexual Difficulties	☐ Yes	☐ No		
Tingling in Hands & Feet	☐ Yes	☐ No		
Urinary Problems	☐ Yes	☐ No		
Cold, Clammy, Pale Skin	☐ Yes	☐ No		
Depression	☐ Yes	☐ No		
Fainting	☐ Yes	☐ No		
Lack of Concentration	☐ Yes	☐ No		
Lack of Energy	☐ Yes	☐ No		
Rapid Shallow Breathing	☐ Yes	☐ No		
Exercise Intolerance	☐ Yes	☐ No		
Painful Contact with Sock or Bed	☐ Yes	☐ No		
Pebble or Sand-like Sensation in Shoes	☐ Yes	☐ No		
Stabbing or Electrical Shock Sensation	☐ Yes	☐ No		
Pins & Needles in Feet	☐ Yes	☐ No		
Blurred Vision	☐ Yes	☐ No		
Elevated Blood Sugar	☐ Yes	☐ No		
Extreme Thirst	☐ Yes	☐ No		
Fatigue	☐ Yes	☐ No		
Increased Hunger	☐ Yes	☐ No		
Heartburn	☐ Yes	☐ No		
Pain In Calves	☐ Yes	☐ No		
Angina	☐ Yes	☐ No		
Chest Pain that Goes Away with Rest	☐ Yes	☐ No		
Shortness of Breath	☐ Yes	☐ No		
TIA (Mini Stroke)	☐ Yes	☐ No		
Blood Clot in a Vein	☐ Yes	☐ No		
Heart Attack	☐ Yes	☐ No		
Irregular Heartbeat (Too Fast/Slow)	☐ Yes	☐ No		
Stroke	☐ Yes	☐ No		