



WEEKLY SYMPTOM CHECKLIST FOR CHILDREN

Name _____ Date _____

Date of Birth _____ Age _____ Height _____ Weight _____ Blood Type _____

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
 _____ Bloating 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** _____