Denver Biofeedback Clinic, Inc.

SYMPTOM CHECKLIST

Name: ______________________________ Date: ____________________

___HEADACHES
___HIGH BLOOD PRESSURE
___RINGING IN EARS
___POUNDING HEART
___CONSTIPATION
___LOOSE BOWELS/DIARRHEA
___ULCER/INDIGESTION
___NAUSEA/VOMITING
___FAINTNESS/DIZZINESS
___ALLERGIES
___ARTHRITIS
___TIGHT KNOT IN STOMACH
___ITCHING/RASHES
___SWEATY PALMS
___SHORTNESS OF BREATH
___COLD HANDS/FEET
___FEELING TENSE/NERVOUS

DIET:
___POOR APPETITE
___OVER-EATING
___SKIP MEALS...HOW OFTEN______________
___CAFFEINE...HOW OFTEN________________
___SUGAR...HOW OFTEN__________________

HOW OFTEN DO YOU:
USE ALCOHOL__________________________
USE RECREATIONAL DRUGS______________
EXERCISE_____________________________
SMOKE_______________________________

SLEEP:
NUMBER OF HOURS PER NIGHT___________
HOW LONG TO FALL ASLEEP____________
SLEEP POSITION: STOMACH ____ BACK____ SIDE (RIGHT)____ (LEFT) ____

PAIN SCALE: FROM 0 TO 10
0 = NO PAIN, 10 = SEVERE
JAW___ HEAD___ NECK___ ARM___
HIP___ SHOULDER___ LEG___
BACK___ HAND___ FEET___

STRESS SCALE: FROM 0 TO 10
WORK:___
HOME:___

___EASILY ANNOYED/IRRITATED
___DIFFICULTY CONCENTRATING
___OBSESSIVE THINKING
___ANGER
___DEPRESSION
___INCREASED WORRYING/FEARFUL THINKING
___IMPAIRED JUDGEMENT
___JOB DISSATISFACTION
___LOWERED SELF-ESTEEM
___ACCIDENT-PRONE
___TENDENCY FOR ERRORS

JAW PAIN:
___JAW TENSION
___POPPING/CLICKING
___PAIN AFTER EATING
___PAIN ON AWAKENING
___CLENCHING/GRINDING....DAY/NIGHT
___TMJ SPLINT
___JAW LOCKS: OPEN____ CLOSED____

IF YOU HAVE UNRESTFUL SLEEP, PLEASE ANSWER THE FOLLOWING QUESTIONS:

What time do you get ready to go to bed at night?________ What time do you go to bed?_______________
Do you read or watch TV or work in your bed or bedroom?____
Do you wake up during the night?______________ How many times? __________________________
If you wake up, do you know why? Explain____
Are you able to fall back to sleep?_______ How long does it take to fall back to sleep?_________________
Do you feel rested in the morning?____
What time do you wake up in the morning?___________ What time do you get out of bed?______________
Do you fall back to sleep in the mornings?____________ Do you take naps during the day?_____________
Do you drink coffee, caffeinated sodas, teas or eat chocolate?_______________________________
How often?____________________ When is the latest you will have caffeine?___________________
Do you drink alcohol in the evening?__________________________ How often?_______________________