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Questionnaire for ME/CFS and FMS Clients - Date: _____

Questions	Check for "Yes" only
I suffer from physical fatigue	
My concentration is reduced	
I have difficulty getting to sleep	
I often have vivid/weird dreams	
My sleep is usually disturbed	
I have problems with short term memory	
I find it difficult to read	
I get brain fog	
I suffer from sinusitis	
I suffer from head pain	
I suffer from neck pain	
I suffer from shoulder pain	
I suffer from upper back pain	
I suffer from lower back pain	
I suffer from other joint pain	
I suffer from joint swelling	
I suffer from general muscle pain	
I often suffer from numbness	
I often suffer from "pins and needles" feelings	
I suffer from redness in the face	
I suffer from frequent rashes	
I suffer from dry skin	
I suffer from frequent spots on my forehead	
I suffer from frequent spots on my back	
I suffer from frequent spots on my chest	



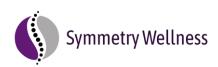
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I feel depressed	
I feel anxious	
I suffer from panic attacks	
I am sensitive to bright light	
I am sensitive to loud noise/suffer from tinnitus	
My temperature fluctuates	
I suffer from bad breath	
I suffer from thrush	
I have problems with my bowels	
I have problems with my bladder	
I am sensitive to smells	
I have food intolerances/allergies	
I have lumpy breasts	
I have tenderness/pain in the chest	
I am frequently breathless	
I suffer from palpitations	
I suffer from sore throats	
I suffer from nausea	
I suffer from dry eyes	
I suffer from dry mouth	
I sweat a lot	
I suffer from cold hands/feet	
I suffer from mood swings	
I suffer from PMS (female only)	
My symptoms are worse during menstruation (female only)	



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Quality of Life

How has your life been affected by these symptoms? Check only one:		
Able to continue as normal		
Only able to work part-time/struggling to cope with work		
Unable to work but not housebound		
Housebound		
Totally bedridden		
Longevity of Symptoms		

Longevity of Symptoms			
How long have you had these symp	ptoms? Check only one:		
10+ years			
Do you have any other comments to	share with me regarding your symptoms? If so	, please state	
them here.			
Name (printed):			
Signature:	Date:		