Symmetry Wellness
Email: symmetrymedmx@gmail.com
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Address: 333 W. Hampden Ave, Suite #420E, Englewood CO 80110

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

How long have you had these symptoms? Check only one:	
Under 12 months	
1-4 years	
5-10 years	
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:_____