HARPER CLINIC

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Please can you indicate if you have any of the following symptoms and the severity of them.
This will be really useful to assess you and also to evaluate your response to any treatment.

Name:

Email Address:

Date:

Symptom Score sheet

Please indicate the extent to which you are bothered at the moment by any of these symptoms by placing a tick in the appropriate box:

SYMPTOMS	NOT AT ALL 0	A LITTLE 1	QUITE A BIT 2	EXTREMELY 3	COMMENT
Heart beating quickly or strongly					
Feeling tense or nervous					
Difficulty in sleeping					
Excitable					
Attacks of anxiety, panic					
Difficulty in concentrating					
Feeling tired or lacking energy					
Loss of interest in most things					
Feeling unhappy or depressed					
Crying spells					
Irritability					
Feeling dizzy or faint					
Pressure or tightness in head					
Parts of body feel numb					
Headaches					
Muscles and joint pains					
Loss of feeling in hands or feet					
Breathing difficulties					
Hot flushes					
Sweating at night					
Loss of interest in sex					
SCORE (practitioner to complete)					
TOTAL SCORE (for practitioner to complete)					