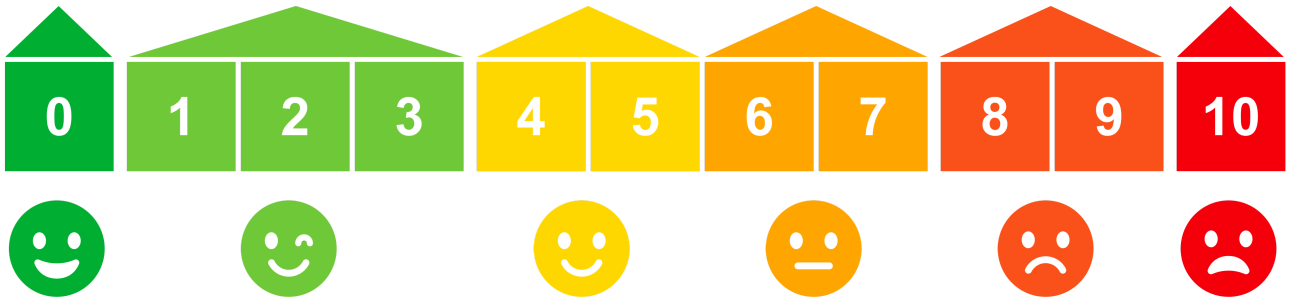
Symptom Severity Scale

Patient information	
Name: John Doe	Date of birth: 15/06/1985
Practitioner: Dr. Smith	Date: 05/02/2025
Reason for visit:	

Instructions

Use this form to share details about symptoms that are causing discomfort, worry, or distress. This information will help us provide the best care for you.



Date	Symptom	Severity (0-10)	Possible cause or trigger	Additional comments
01/02/2025	Difficulty sleeping	7	Stress, anxiety	Trouble falling asleep
01/02/2025	Appetite changes	6	Stress, anxiety	Decreased appetite
01/02/2025	Nausea	5	Skipping meals, stress	mostly in the morning
	Digestive issues			
	Breathing problems			
01/02/2025	Fatigue or low energy	8	Poor sleep, diet	Feels exhausted even afte
	Pain Specify area:			
	Other Specify:			

How long have you been experiencing these symptoms?
Around three months, progressively worsening.
What makes the symptoms worse? Does anything make them better?
Worse: Stress, certain foods, poor sleep. Better: Light exercise, herbal teas, occasional rest days.
How are these symptoms affecting your daily life or usual activities?
Difficulty concentrating at work, avoiding social events, lower productivity.
What would you like to achieve or discuss during this visit?
Possible diagnosis, treatment options, dietary recommendations, and stress management strategies.
Additional notes
Interested in exploring natural remedies or lifestyle changes before considering medication.

Caresearch. (n.d.). *Assessing symptoms - patient assessment - general practitioner - health professionals*. https://www.caresearch.com.au/Health-Professionals/General-Practitioner/Patient-Assessment/Assessing-Symptoms