

# Symptom Severity Scale

## Patient information

Name:

Date of birth:

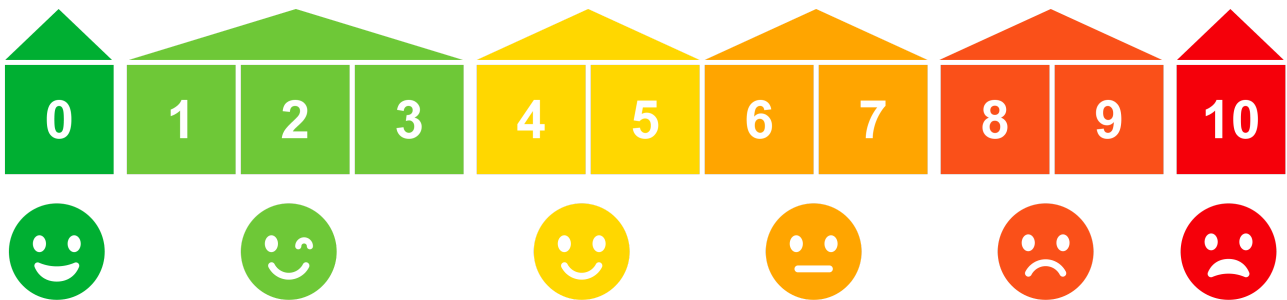
Practitioner:

Date:

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
	Difficulty sleeping			
	Appetite changes			
	Nausea			
	Digestive issues			
	Breathing problems			
	Fatigue or low energy			
	Pain Specify area:			
	Other Specify:			

How long have you been experiencing these symptoms?

What makes the symptoms worse? Does anything make them better?

How are these symptoms affecting your daily life or usual activities?

What would you like to achieve or discuss during this visit?

**Additional notes**