

SYMPTOM SURVEY: 4 WEEK RESET

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DR. CHRISTIANSON.com

Please rate the following symptoms each day at bedtime. Rate each from 1 - 5, 1 being lowest, 5 being highest.

STARTING DATE: _____ **ENDING DATE:** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Food Cravings																												
Poor Quality Sleep																												
Fatigue Throughout the Day																												
Unusual Gas and Bloating																												
Muscle Pain																												
Severe Brain Fog																												
New Skin Rashes																												
Loose or Erratic Stools																												
Abnormal Headaches																												
Nasal Congestion																												



Light ← → Severe
Moderate