

## Medical Symptoms Questionnaire (MSQ)

| Patient Name                                                                                                                                     |                                                                                                      | Date                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------|--|
| Rate each of the follow                                                                                                                          | ing symptoms based upon your typ                                                                     | pical health profile for the past 14 days.  |  |
| Point Scale 0 – Never or almost never have the symptom 1 – Occasionally have it, effect is not severe 2 – Occasionally have it, effect is severe |                                                                                                      |                                             |  |
| HEAD                                                                                                                                             | Headaches Faintness Dizziness Insomnia                                                               | Total                                       |  |
| EYES                                                                                                                                             | Watery or itchy eye Swollen, reddened Bags or dark circles Blurred or tunnel v (Does not include ned | or sticky eyelids s under eyes vision Total |  |
| EARS                                                                                                                                             | Itchy ears Earaches, ear infect Drainage from ear Ringing in ears, he                                |                                             |  |
| NOSE                                                                                                                                             | Stuffy nose Sinus problems Hay fever Sneezing attacks Excessive mucus fo                             | rmation <b>Total</b>                        |  |
| MOUTH/THROAT                                                                                                                                     | Chronic coughing Gagging, frequent 1 Sore throat, hoarser Swollen or discolor Canker sores           |                                             |  |
| SKIN                                                                                                                                             | Acne Hives, rashes, dry sk Hair loss Flushing, hot flashe Excessive sweating                         |                                             |  |
| HEART                                                                                                                                            | Irregular or skipped Rapid or pounding Chest pain                                                    |                                             |  |

## LUNGS Chest congestion Asthma, bronchitis Shortness of breath \_\_\_\_\_ Difficulty breathing Total \_\_\_\_\_ **DIGESTIVE TRACT** \_\_\_\_\_ Nausea, vomiting Diarrhea \_\_\_\_\_ Constipation \_\_\_\_\_ Bloated feeling \_\_\_\_\_ Belching, passing gas \_\_\_\_ Heartburn \_\_\_\_\_ Intestinal/stomach pain Total JOINTS/MUSCLE Pain or aches in joints Arthritis Stiffness or limitation of movement Pain or aches in muscles Feeling of weakness or tiredness Total \_\_\_\_\_ **WEIGHT** Binge eating/drinking \_\_\_\_\_ Craving certain foods Excessive weight \_\_\_\_\_ Compulsive eating \_\_\_\_\_ Water retention \_\_\_\_ Underweight Total \_\_\_\_\_ **ENERGY/ACTIVITY** \_\_\_\_\_ Fatigue, sluggishness \_\_\_\_\_ Apathy, lethargy \_\_\_\_\_ Hyperactivity Restlessness Total MIND \_\_\_\_\_ Poor memory Confusion, poor comprehension Poor concentration \_\_\_\_\_ Poor physical coordination \_\_\_\_\_ Difficulty in making decisions \_\_\_\_\_ Stuttering or stammering \_\_\_\_\_ Slurred speech \_\_\_\_\_ Learning disabilities Total \_\_\_\_\_ **EMOTIONS** \_\_\_\_\_ Mood swings \_\_\_\_\_ Anxiety, fear, nervousness \_\_\_\_\_ Anger, irritability, aggressiveness \_\_\_\_\_ Depression Total \_\_\_\_\_ **OTHER** \_\_\_\_\_ Frequent illness \_\_\_\_\_ Frequent or urgent urination Genital itch or discharge Total Grand Total

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