

Medical Symptoms Questionnaire (MSQ)

| Patient Nam | e | Date |
|------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------|
| Data cach a | f the following symptoms based upon your type | nical health profile for the past 14 days |
| | | |
| Point Scale $0 - Never or almost never have the symp 1 - Occasionally have it, effect is not seven$ | | |
| | 2 – Occasionally have it, effect is severe | 4 - Frequently mave it, effect is severe |
| | 2 - Occusionary mave it, effect is severe | |
| LIEAD | | |
| HEAD | Headaches | |
| | Faintness | |
| | Dizziness | |
| | Insomnia | Total |
| EYES | Watery or itchy eye | es |
| | Swollen, reddened | |
| | Bags or dark circles | |
| | Blurred or tunnel v | |
| | (Does not include ned | ar or far-sightedness) |
| E A DC | | |
| EARS | Itchy ears | |
| | Earaches, ear infect | ions |
| | Drainage from ear | |
| | Ringing in ears, he | earing loss Total |
| NOSE | Stuffy nose | |
| | Sinus problems | |
| | Hay fever | |
| | Sneezing attacks | |
| | Excessive mucus fo | ormation Total |
| MOUTH/T | HROAT Chronic coughing | |
| · | Gagging, frequent i | |
| | Sore throat, hoarser | |
| | | red tongue, gums, lips |
| | Sworth of discoord | Total |
| | Gainter sores | |
| SKIN | Acne | |
| | Hives, rashes, dry sk | kin |
| | Hair loss | |
| | Flushing, hot flashe | |
| | Excessive sweating | Total |
| HEART | Irregular or skipped | d heartbeat |
| | Rapid or pounding | |
| | Chest pain | Total |
| | Onest 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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