Patient Name: ______________________________ **Date:** ____________

Rate each of the following symptoms based on your typical health profile for the specified duration:

❐ Past month ❐ Past week ❐ Past 48 hours

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*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD
- ______ Headaches
- ______ Faintness
- ______ Dizziness
- ______ Insomnia **TOTAL** ______

EYES
- ______ Watery or itchy eyes
- ______ Swollen, reddened or sticky eyelids
- ______ Bags or dark circles under eyes
- ______ Blurred or tunnel vision **TOTAL** ______

EARS
- ______ Itchy ears
- ______ Earaches, ear infections
- ______ Drainage from ear
- ______ Ringing in ears, hearing loss **TOTAL** ______

NOSE
- ______ Stuffy nose
- ______ Sinus problems
- ______ Hay fever
- ______ Sneezing attacks
- ______ Excessive mucus formation **TOTAL** ______

MOUTH/ THROAT
- ______ Chronic coughing
- ______ Gagging, frequent need to clear throat
- ______ Sore throat, hoarseness, loss of voice
- ______ Swollen or discolored tongue, gums, lips
- ______ Canker sores **TOTAL** ______

SKIN
- ______ Acne
- ______ Hives, rashes, dry skin
- ______ Hair loss
- ______ Flushing, hot flashes
- ______ Excessive sweating **TOTAL** ______

HEART
- ______ Chest pain
- ______ Irregular or skipped heartbeat
- ______ Rapid or pounding heartbeat **TOTAL** ______

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
- ______ Feeling of weakness or tiredness
- ______ Pain or aches in muscles **TOTAL** ______

WEIGHT
- ______ Binge eating/drinking
- ______ Craving certain foods
- ______ Excessive weight
- ______ Water retention
- ______ Underweight
- ______ Compulsive eating **TOTAL** ______

ENERGY/ ACTIVITY
- ______ Fatigue, sluggishness
- ______ Apathy, lethargy
- ______ Hyperactivity
- ______ Restlessness **TOTAL** ______

MIND
- ______ Poor memory
- ______ Confusion, poor comprehension
- ______ Difficulty in making decisions
- ______ Stuttering or stammering
- ______ Slurred speech
- ______ Learning disabilities
- ______ Poor concentration
- ______ Poor physical coordination **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 **TOTAL** ______