



MSQ - Medical Symptom Questionnaire: A Functional Medicine Assessment

Name: _____

Date: _____

DIRECTIONS FOR COMPLETING THE QUESTIONNAIRE:

Rate the following symptoms based upon your typical health profile for the last 30 days.

Use the following "Point Scale":

- 0= **Never or almost never** have the symptoms
- 1= **Occasionally** have symptom, effect is **NOT severe**
- 2= **Occasionally** have symptom, effect is **severe**
- 3= **Frequently** have symptom, effect is **NOT severe**
- 4= **Frequently** have symptom, effect is **severe**

Be sure to add the points up for each individual group of symptoms.

At the end of the questionnaire, don't forget to tally the "GRAND TOTAL" of all of the symptom groups.

SYMPTOMS	0	1	2	3	4
HEAD					
Headache					
Faintness					
Dizziness					
Insomnia					
				Total=	<input type="text"/>
EYES					
Watery, itchy eyes					
Swollen, reddened, or sticky eyelids					
Bags or dark circles under eyes					
Blurred or tunnel vision					
				Total=	<input type="text"/>
EARS					
Itchy ears					
Earaches, ear infections					
Drainage from ears					
Ringling in ears, hearing loss					
				Total=	<input type="text"/>
NOSE					

Stuffy nose					
Sinus problems					
Hay fever					
Sneezing attacks					
Excessive mucus formation					
				Total=	<input type="text"/>
MOUTH/THROAT					
Chronic cough					
Gagging, frequent need to clear throat					
Sore throat, hoarseness, loss of voice					
Swollen or discolored tongue, gums, lips					
Canker sores					
				Total=	<input type="text"/>
SKIN					
Acne					
Hives, rashes, dry skin					
Hair loss					
Flushing, hot flashes					
Excessive sweating					
				Total=	<input type="text"/>
HEART					
Irregular or skipped heartbeats					
Rapid or pounding heartbeat					
Chest pain					
				Total=	<input type="text"/>
LUNGS					
Chest congestion					
Asthma, bronchitis					
Shortness of breath					
Difficulty breathing					
				Total=	<input type="text"/>

DIGESTIVE TRACT					
Nausea, vomiting					
Diarrhea					
Constipation					
Bloated feeling					
Belching, passing gas					
Heartburn					
Intestinal/stomach pain					
				Total=	<input type="text"/>
JOINTS/MUSCLES					
Pain or aches in joints					
Arthritis					
Stiffness or limitations of movement					
Pain or aches in muscles					
Feeling of weakness or tiredness					
				Total=	<input type="text"/>
WEIGHT					
Binge eating/drinking					
Craving certain foods					
Excessive weight					
Compulsive eating					
Water retention					
Underweight					
				Total=	<input type="text"/>
ENERGY/ACTIVITY					
Fatigue, sluggishness					
Apathy, lethargy					
Hyperactivity					
Restlessness					
				Total=	<input type="text"/>
MIND					

Poor memory					
Confusion, poor comprehension					
Poor concentration					
Poor physical coordination					
Difficulty in making decisions					
Stuttering or stammering					
Slurred speech					
Learning disability					
				Total=	<input type="text"/>
EMOTIONS					
Mood swings					
Anxiety, fear, nervousness,					
Anger, irritability, aggressiveness					
Depression					
				Total=	<input type="text"/>
OTHER					
Frequent illness					
Frequent or urgent urination					
Genital itch or discharge					
				Total=	<input type="text"/>
				Grand Total=	<input type="text"/>

Thank you for completing this questionnaire.

Please be sure to print out the test and bring it with you to your appointment.