



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.

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

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

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

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