

MSQ

Patient Name: _____

Date: _____

Directions: Rate each of the following symptoms based upon your typical health for the past 30 days.

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

HEAD

- _____ Headaches
- _____ Faintness
- _____ Dizziness
- _____ Insomnia

EYES

- _____ Watery or Itchy Eyes
- _____ Swollen, reddened or sticky eyelids
- _____ Bags or dark circles under eyes
- _____ Blurred or tunnel vision
(not including near or far-sightedness)

EARS

- _____ Itchy ears
- _____ Earaches, ear infections
- _____ Drainage from ear
- _____ Ringing in ears, hearing loss

NOSE

- _____ Stuffy Nose
- _____ Sinus problems
- _____ Hay fever
- _____ Sneezing Attacks
- _____ Excessive mucus formation

MOUTH/THROAT

- _____ Chronic coughing
- _____ Gagging, frequent need to clear throat
- _____ Sore throat, hoarseness, loss of voice
- _____ Canker sores
- _____ Swollen or discolored gums, tongue or lips

SKIN

- _____ Acne
- _____ Hives, rashes, dry skin
- _____ Hair loss
- _____ Flushing, hot flashes
- _____ Excessive sweating

HEART

- _____ Irregular or skipped heartbeat
- _____ Rapid or pounding heartbeat
- _____ Chest pain
- _____ High cholesterol, C-reactive Protein, homocysteine

MSQ

LUNGS

- _____ Chest congestion
- _____ Asthma, bronchitis
- _____ Shortness of breath
- _____ Difficulty breathing

DIGESTIVE TRACT

- _____ Nausea, vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Bloating feeling
- _____ Reflux or heartburn
- _____ Belching, passing gas
- _____ Intestinal/stomach pain

JOINTS/MUSCLES

- _____ Pain or aches in joints
- _____ Arthritis
- _____ Stiffness or limitation of movement
- _____ Pain or aches in muscles
- _____ Feeling of weakness or tiredness

WEIGHT

- _____ Binge eating/drinking
- _____ Craving certain foods
- _____ Excessive weight
- _____ Compulsive eating
- _____ Water retention
- _____ Underweight

ENERGY/ACTIVITY

- _____ Fatigue, sluggishness
- _____ Apathy, lethargy
- _____ Hyperactivity
- _____ Restlessness

MIND

- _____ Poor memory
- _____ Confusion, poor comprehension
- _____ Poor concentration
- _____ Poor physical coordination
- _____ Difficulty in making decisions

EMOTIONS

- _____ Mood swings
- _____ Anxiety, fear
- _____ Anger, irritability, aggressiveness
- _____ Depression

OTHER

- _____ Frequent illness
- _____ Frequent or urgent urination
- _____ Genital itch or discharge

WHAT IS YOUR MAIN HEALTH GOAL?: _____

Most of the above symptoms can be minimized through nutrition and supplementation.