MSQ: Symptom Questionnaire

Client: _____ Date: _____

Please circle the number that best describes the frequency and severity of your symptoms according to the following point scale:

0 = I never or rarely have this symptom
1 = I occasionally have mild symptoms
2 = I occasionally have severe symptoms
3 = I frequently have mild symptoms
4 = I frequently have severe symptoms

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0 1 2 3 4	headaches		0 1 2 3 4	nausea and/or vomiting
0 1 2 3 4	faintness		0 1 2 3 4	diarrhea
0 1 2 3 4	dizziness		0 1 2 3 4	constipation
0 1 2 3 4	insomnia		0 1 2 3 4	bloated feeling
	Section TOTAL		0 1 2 3 4	belching, passing gas
			0 1 2 3 4	heartburn
0 1 2 3 4	watery or itchy eyes		0 1 2 3 4	intestinal/stomach pain
0 1 2 3 4	swollen, red or sticky eyelids			**Section TOTAL**
0 1 2 3 4	undereye bags or dark circles			
0 1 2 3 4	blurred or tunnel vision		0 1 2 3 4	pain or aches in joints
0 1 2 3 4	(not including far or nearsight-		0 1 2 3 4	arthritis
	edness)		0 1 2 3 4	stiffness or limited movement
	Section TOTAL		0 1 2 3 4	muscle aches or cramps
			0 1 2 3 4	weak or tired muscles
0 1 2 3 4	itchy ears			**Section TOTAL**
0 1 2 3 4	earaches, ear infections			
0 1 2 3 4	drainage from the ear		0 1 2 3 4	binge eating/drinking
0 1 2 3 4	ringing in ears, hearing loss		0 1 2 3 4	craving certain foods
	Section TOTAL		0 1 2 3 4	excessive weight
			0 1 2 3 4	compulsive eating
0 1 2 3 4	stuffy nose		0 1 2 3 4	water retention
0 1 2 3 4	sinus problems		0 1 2 3 4	underweight
0 1 2 3 4	hay fever			**Section TOTAL**
0 1 2 3 4	sneezing attacks			
0 1 2 3 4	excessive mucus formation		0 1 2 3 4	fatigue, sluggishness
	Section TOTAL		0 1 2 3 4	apathy, lethargy
			0 1 2 3 4	hyperactivity
0 1 2 3 4	chronic coughing		0 1 2 3 4	restlessness
0 1 2 3 4	gagging, need to clear throat			**Section TOTAL**
0 1 2 3 4	sore throat, hoarseness			
0 1 2 3 4	swollen or discoloured tongue		0 1 2 3 4	irregular heartbeat
0 1 2 3 4	canker sores		0 1 2 3 4	rapid or pounding heartbeat
	Section TOTAL		0 1 2 3 4	chest pain
				Section TOTAL

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0 1 2 3 4	hives, rashes, eczema
0 1 2 3 4	hair loss, dry scalp
0 1 2 3 4	flushing, hot flashes
0 1 2 3 4	excessive perspiration
	Section TOTAL
0 1 2 3 4	chest congestion
0 1 2 3 4	asthma, bronchitis
0 1 2 3 4	shortness of breath
0 1 2 3 4	difficulty breathing
	Section TOTAL
0 1 2 3 4	poor memory
0 1 2 3 4	confusion
0 1 2 3 4	poor concentration
0 1 2 3 4	poor co-ordination
0 1 2 3 4	difficulty making decisions
0 1 2 3 4	stuttering or stammering
0 1 2 3 4	slurred speech
0 1 2 3 4	learning disabilities
	Section TOTAL
0 1 2 3 4	mood swings
0 1 2 3 4	anxiety, fear, nervousness
0 1 2 3 4	anger, irritability, aggressive
0 1 2 3 4	depression
	Section TOTAL
0 1 2 3 4	frequent illness
0 1 2 3 4	frequent or urgent urination
0 1 2 3 4	genital itch or discharge
0 1 2 3 4	premenstrual discomfort
0 1 2 3 4	painful or heavy periods
	Section TOTAL