

MSQ – Medical Symptom/Toxicity Questionnaire



Name: _____ Date of Birth: _____

Date MSQ Completed: _____ Baseline After Changes

This Questionnaire identifies symptoms that help to identify the underlying cause of illness and helps you track your progress over time. Rate each of the following symptoms based upon your health profile. Please indicate if this is baseline or how long after changes that you are completing this.

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*

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 (not near or far-sightedness)

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/discolored tongue, gum, lips
- ___ Canker sores

Total _____

HEART

- ___ Irregular or skipped heartbeat
- ___ Rapid or pounding heartbeat
- ___ Chest pain

Total _____

LUNGS

- ___ Chest congestion
- ___ Asthma, bronchitis
- ___ Shortness of breath
- ___ Difficult breathing

Total _____

DIGESTIVE TRACT

- ___ Nausea or vomiting
- ___ Diarrhea
- ___ Constipation
- ___ Bloating feeling
- ___ Belching or passing gas
- ___ Heartburn
- ___ Intestinal/Stomach pain

Total _____

JOINTS/MUSCLES

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

Total _____

SKIN

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

Total _____

EMOTIONS

- ___ Mood swings
- ___ Anxiety, fear or nervousness
- ___ Anger, irritability or aggressiveness
- ___ Depression

Total _____

ENERGY/ACTIVITY

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

Total _____

MIND

- ___ Poor memory
- ___ Confusion, poor comprehension
- ___ Poor physical coordination
- ___ Difficulty in making decisions
- ___ Stuttering or stammering
- ___ Slurred speech
- ___ Learning disabilities

Total _____

WEIGHT

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

Total _____

OTHER

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

Total _____

Key: *Optimal: <10* *Mild Toxicity: 10-50*
Moderate Toxicity: 50-100 *Severe Toxicity: >100*

GRAND

TOTAL _____