

MSQ - Multiple Symptoms Questionnaire

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

Point Scale:

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Frequently have it, effect is not severe

3 = Occasionally have it, effect is severe

4 = Frequently have it, effect is severe

Digestive Tract	<input type="checkbox"/> Nausea or vomiting	Total	Lungs	<input type="checkbox"/> Chest Congestion	Total
	<input type="checkbox"/> Diarrhea			<input type="checkbox"/> Asthma, bronchitis	
	<input type="checkbox"/> Constipation			<input type="checkbox"/> Shortness of breath	
	<input type="checkbox"/> Bloating Feeling			<input type="checkbox"/> Difficulty Breathing	
	<input type="checkbox"/> Belching or passing gas			<input type="checkbox"/> Cold Hands / Feet	
	<input type="checkbox"/> Heartburn			<input type="checkbox"/> Numbness / Tingling	
Ears	<input type="checkbox"/> Itchy Ears	Total	Mind	<input type="checkbox"/> Poor memory	Total
	<input type="checkbox"/> Ear aches, ear infections			<input type="checkbox"/> Confusion, poor comprehension	
	<input type="checkbox"/> Drainage from ears			<input type="checkbox"/> Difficulty in making decisions	
	<input type="checkbox"/> Ringing in ears, hearing loss			<input type="checkbox"/> Stuttering or stammering	
	<input type="checkbox"/> Poor balance			<input type="checkbox"/> Difficulty focusing / attention	
	<input type="checkbox"/> Vertigo /Room spins			<input type="checkbox"/> Learning disabilities	
Emotions	<input type="checkbox"/> Mood swings	Total	Mouth/ Throat	<input type="checkbox"/> Chronic coughing	Total
	<input type="checkbox"/> Anxiety, fear or nervousness			<input type="checkbox"/> Gagging frequently; clearing throat	
	<input type="checkbox"/> Anger, irritability or aggressiveness			<input type="checkbox"/> Sore throat, hoarseness, loss of voice	
	<input type="checkbox"/> Depression			<input type="checkbox"/> Swollen / discolored tongue, gums, lips	
	<input type="checkbox"/> Lack of dreaming			<input type="checkbox"/> Jaw pain / clicking / teeth grinding	
	<input type="checkbox"/> Bad dreams / nightmares			<input type="checkbox"/> Speech problems	
	<input type="checkbox"/> Rapid Heartbeat			<input type="checkbox"/> Canker sores	
Energy & Activity	<input type="checkbox"/> Fatigue, sluggishness	Total	Nose	<input type="checkbox"/> Stuffy nose	Total
	<input type="checkbox"/> Apathy, lethargy			<input type="checkbox"/> Sinus problems	
	<input type="checkbox"/> Hyperactivity			<input type="checkbox"/> Hay fever / Allergies	
	<input type="checkbox"/> Restlessness			<input type="checkbox"/> Sneezing attacks	
	<input type="checkbox"/> Muscle twitching			<input type="checkbox"/> Excessive mucus formation	
Eyes	<input type="checkbox"/> Watery or itchy eyes	Total	Skin	<input type="checkbox"/> Acne	Total
	<input type="checkbox"/> Swollen, reddened or sticky eyelids			<input type="checkbox"/> Hives, rashes, or dry skin	
	<input type="checkbox"/> Bags or dark circles under eyes			<input type="checkbox"/> Hair loss	
	<input type="checkbox"/> Blurred or tunnel vision			<input type="checkbox"/> Flushing or hot flashes	
	<input type="checkbox"/> Eyes sensitive to light			<input type="checkbox"/> Excessive sweating	
Head	<input type="checkbox"/> Headaches	Total	Weight	<input type="checkbox"/> Binge eating	Total
	<input type="checkbox"/> Faintness			<input type="checkbox"/> Craving certain foods	
	<input type="checkbox"/> Dizziness / Black outs			<input type="checkbox"/> Excessive weight	
	<input type="checkbox"/> Insomnia / Sleep problems			<input type="checkbox"/> Compulsive eating	
	<input type="checkbox"/> Disinterest in sex			<input type="checkbox"/> Water retention	
	<input type="checkbox"/> Cry Easily			<input type="checkbox"/> Underweight	
Heart	<input type="checkbox"/> Irregular or skipped heartbeat	Total	Other	<input type="checkbox"/> Frequent illness	Total
	<input type="checkbox"/> Rapid or pounding heartbeat			<input type="checkbox"/> Frequent or urgent urination	
	<input type="checkbox"/> Hands shake / Tremors			<input type="checkbox"/> PMS / Menstrual irregularity	
	<input type="checkbox"/> Chest Pain			<input type="checkbox"/> Genital itch or discharge	
Joints & Muscles	<input type="checkbox"/> Pain or aches in joints	Total		<i>Grand Total</i>	
	<input type="checkbox"/> Arthritis				
	<input type="checkbox"/> Stiffness or limitation of movement				
	<input type="checkbox"/> Pain or aches in muscles				
	<input type="checkbox"/> Feeling of weakness or tiredness				