

# MSQ - Metabolic Symptoms Questionnaire

**True Health Family Wellness Center; 1095 Hendersonville Road Suite A Asheville, NC 28803 Phone 277-1414**

Rate each of the following symptoms, habits, tendencies as to how frequent and severe you notice them...

<b>Point Scale:</b>	2 = Mildly noticeable, occasional, moderate to severe
0 = Never or almost never have the symptom	3 = Moderately noticeable, more frequent, more severe
1 = Slightly noticeable, occasional and mild	4 = Very noticeable, very often, and severe

NAME \_\_\_\_\_

DATE \_\_\_\_\_

<b>PANCREAS/INSULIN</b>	<input type="checkbox"/> Apple shaped weight gain <input type="checkbox"/> Abdominal / Belly fat <input type="checkbox"/> Feel Shaky, Jittery, tremors <input type="checkbox"/> Irritable, esp. with missed meal <input type="checkbox"/> Dizziness or faint feeling <input type="checkbox"/> Increased thirst or hunger <input type="checkbox"/> Heart palpitations or flutter <input type="checkbox"/> Feeling weak or lethargic <input type="checkbox"/> Clammy skin, hands, feet <input type="checkbox"/> Tingling sensation in hands, feet <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Poor memory, forgetful <input type="checkbox"/> Numbness in hands or feet <input type="checkbox"/> Frequent urination <input type="checkbox"/> Bladder infections <input type="checkbox"/> Restlessness or trouble sitting still <input type="checkbox"/> Night restlessness, difficulty staying asleep <input type="checkbox"/> Fatigue or headache, relieved by eating <input type="checkbox"/> Binge eating <input type="checkbox"/> Crave sweets <p style="text-align: right;">TOTAL _____</p>	<b>THYROID/THYROXINE</b>	<input type="checkbox"/> All over body weigh gain, arms and calves <input type="checkbox"/> Morning headaches <input type="checkbox"/> Increase in weight despite a low calorie diet <input type="checkbox"/> Sensitive to cold <input type="checkbox"/> Dry or brittle hair <input type="checkbox"/> Dry or itching skin <input type="checkbox"/> Lack of motivation, drive <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Catch colds easily, slow to heal <input type="checkbox"/> Slow wound healing <input type="checkbox"/> Require lots of sleep >8 hours <input type="checkbox"/> Chronic digestive problems <input type="checkbox"/> Thinning of outside portion of eyebrows <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Tendency toward constipation <input type="checkbox"/> Poor circulation <input type="checkbox"/> Low body temperature <input type="checkbox"/> Easily fatigued <p style="text-align: right;">TOTAL _____</p>
<b>ADRENAL/CORTISOL</b>	<input type="checkbox"/> Weight gain in upper body, thin legs <input type="checkbox"/> Sensitivity to bright light, sunlight <input type="checkbox"/> Dizziness upon standing quickly <input type="checkbox"/> Tend to be a night person <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> High blood pressure <input type="checkbox"/> Tend to be keyed up, hard to calm down <input type="checkbox"/> Clench or grind teeth <input type="checkbox"/> Headache after exercising <input type="checkbox"/> Calm on the outside, troubled on the inside <input type="checkbox"/> Feel wired or jittery after coffee <input type="checkbox"/> Low energy, feel drowsy often <input type="checkbox"/> Crave salty foods <input type="checkbox"/> Perspire easily <input type="checkbox"/> Dogs like to like you <input type="checkbox"/> Knee pain or shin splints <input type="checkbox"/> Asthma or allergies <input type="checkbox"/> Late afternoon headache <input type="checkbox"/> Afternoon yawning <p style="text-align: right;">TOTAL _____</p>	<b>PITUITARY/HYPOTHALAMUS</b>	<input type="checkbox"/> Weight gain around face <input type="checkbox"/> Fat depositing on back and neck <input type="checkbox"/> Delayed puberty <input type="checkbox"/> Lack of menstruation <input type="checkbox"/> Low libido <input type="checkbox"/> Infertility, erectile dysfunction <input type="checkbox"/> Lack of appetite <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Slow heart rate <input type="checkbox"/> Splitting headache <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Short stature <input type="checkbox"/> Multiple gland symptoms <input type="checkbox"/> Decreased muscle tone <input type="checkbox"/> Fatigue, nausea, dizziness <p style="text-align: right;">TOTAL _____</p>
<b>GONADS/ESTROGEN</b>	<input type="checkbox"/> Pear shaped weight gain, hips, thighs, and butt <input type="checkbox"/> Large breasts, or breast development in men <input type="checkbox"/> Heavy periods <input type="checkbox"/> PMS <input type="checkbox"/> Cramping <input type="checkbox"/> Irregular periods <input type="checkbox"/> Moodiness <input type="checkbox"/> Tendency toward fibroids or cysts <input type="checkbox"/> Acne <input type="checkbox"/> Fluid retention <input type="checkbox"/> Premenstrual headaches <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Night sweats <input type="checkbox"/> Losing, thinning hair <p style="text-align: right;">TOTAL _____</p>	<b>RESULTS</b>	INSULIN..... CORTISOL..... ESTROGEN..... THYROID..... PITUITARY.....