INTEGRATIVE AND FUNCTIONAL NUTRITION ACADEMY™

My Symptom Questionnaire (MySQ)

Name: **Date:**

Rate each of the following symptoms based upon your typical health profile for the *Past 30 days*

0	1	2	3	4	5
Never	Rarely, Effect not severe	Occasionally, Effect not severe	Occasionally, Effect severe	Frequently, Effect not severe	Frequently, Effect severe

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
TOTAL_____

NOSE

_____ Stuffy Nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucous
_____ Loss sense of smell
TOTAL_____

NAILS

_____ Spoon shaped
_____ Brittle, cracking
_____ Discolored
_____ White spots
_____ Lines/Stripes
TOTAL_____

HAIR

_____ Hair thinning
_____ Hair loss
_____ Loss of outer eyebrow hair
_____ Premature greying
_____ Easy hair pluckability
TOTAL_____

SKIN

_____ Acne
_____ Hives, rashes
_____ Dry skin
_____ Bumps on back of arms
_____ Flushing
_____ Excessive sweating
TOTAL_____

IMMUNE

_____ Colds
_____ Flu
_____ Chronic infections
TOTAL_____

EYES

_____ Watery / itchy eyes
_____ Yellowing eyes
_____ Swollen, reddened, sticky eyelids
_____ Bags, dark circles
_____ Night vision problems
_____ Blurred vision
_____ Loss peripheral vision
TOTAL_____

MOUTH/THROAT

_____ Chronic cough
_____ Gagging/throat clearing
_____ Sore throat
_____ Hoarseness
_____ Swollen/discolored tongue
_____ Burning tongue
_____ Coating on tongue
_____ Chewing problems
_____ Swallowing problems
_____ Canker sores
_____ Fever blisters
_____ Cracks corner of mouth
TOTAL_____

HEART

_____ Irregular /skipped beats
_____ Rapid/pounding beats
_____ Chest pain
_____
TOTAL_____

LUNGS

_____ Chest congestion
_____ Asthma or bronchitis
_____ Shortness of breath
_____ Difficulty breathing
TOTAL_____

ENERGY/SLEEP

_____ Fatigue
_____ Lethargy
_____ Hyperactivity
_____ Insomnia
_____ Sleep disruptions
TOTAL_____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing
_____ Hearing loss
TOTAL_____

DIGESTIVE TRACT /GASTROINTESTINAL (GI)

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Alternating diarrhea & constipation
_____ Bloating
_____ Belching
_____ Gas/flatulence
_____ Heartburn
_____ Upper GI pain
_____ Lower abdominal pain
TOTAL_____

JOINTS/MUSCLE/BONE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness/limited movement
_____ Pain or aches in muscles
_____ Feeling of weakness or loss of strength
_____ Restless legs
_____ Bone pain
_____ Broken bones
TOTAL_____

WEIGHT

_____ Underweight
_____ Overweight
_____ Obese
_____ Weight loss (>5-10 lbs)
_____ Weight gain (>5-10 lbs)
_____ Fluid retention
TOTAL_____

NEURO	GENITOURINARY	EMOTIONS
_____ Frequent or urgent urination _____ Itching _____ Discharge _____ Incontinence TOTAL____	_____ Poor memory _____ Confusion _____ Poor concentration/“brain fog” _____ Poor physical coordination _____ Loss of balance _____ Tingling in hands or feet _____ Stuttering or stammering _____ Slurred speech TOTAL____	_____ Mood swings _____ Anxiety, worry, fear, nervousness _____ Anger, irritability, agitation _____ Depression TOTAL____ GRAND TOTAL____ Key: the higher the score, the greater the impact on the individual. 0-15 Fair 16-25 Moderate 26-50 Major >50 Severe