



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		EYES		EARS	
<input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <div style="text-align: right;">TOTAL ____</div>		<input type="checkbox"/> Watery / itchy eyes <input type="checkbox"/> Yellowing eyes <input type="checkbox"/> Swollen, reddened, sticky eyelids <input type="checkbox"/> Bags, dark circles <input type="checkbox"/> Night vision problems <input type="checkbox"/> Blurred vision <input type="checkbox"/> Loss peripheral vision <div style="text-align: right;">TOTAL ____</div>		<input type="checkbox"/> Itchy ears <input type="checkbox"/> Earaches, ear infections <input type="checkbox"/> Drainage from ear <input type="checkbox"/> Ringing <input type="checkbox"/> Hearing loss <div style="text-align: right;">TOTAL ____</div>	
NOSE				DIGESTIVE TRACT /GASTROINTESTINAL (GI)	
<input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hay fever <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Excessive mucous <input type="checkbox"/> Loss sense of smell <div style="text-align: right;">TOTAL ____</div>		MOUTH/THROAT		<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Alternating diarrhea & constipation <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Gas/flatulence <input type="checkbox"/> Heartburn <input type="checkbox"/> Upper GI pain <input type="checkbox"/> Lower abdominal pain <div style="text-align: right;">TOTAL ____</div>	
NAILS					
<input type="checkbox"/> Spoon shaped <input type="checkbox"/> Brittle, cracking <input type="checkbox"/> Discolored <input type="checkbox"/> White spots <input type="checkbox"/> Lines/Stripes <div style="text-align: right;">TOTAL ____</div>		<input type="checkbox"/> Chronic cough <input type="checkbox"/> Gagging/throat clearing <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Swollen/discolored tongue <input type="checkbox"/> Burning tongue <input type="checkbox"/> Coating on tongue <input type="checkbox"/> Chewing problems <input type="checkbox"/> Swallowing problems <input type="checkbox"/> Canker sores <input type="checkbox"/> Fever blisters <input type="checkbox"/> Cracks corner of mouth <div style="text-align: right;">TOTAL ____</div>			
HAIR		HEART		JOINTS/MUSCLE/BONE	
<input type="checkbox"/> Hair thinning <input type="checkbox"/> Hair loss <input type="checkbox"/> Loss of outer eyebrow hair <input type="checkbox"/> Premature greying <input type="checkbox"/> Easy hair pluckability <div style="text-align: right;">TOTAL ____</div>		<input type="checkbox"/> Irregular /skipped beats <input type="checkbox"/> Rapid/pounding beats <input type="checkbox"/> Chest pain <div style="text-align: right;">TOTAL ____</div>		<input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness/limited movement <input type="checkbox"/> Pain or aches in muscles <input type="checkbox"/> Feeling of weakness or loss of strength <input type="checkbox"/> Restless legs <input type="checkbox"/> Bone pain <input type="checkbox"/> Broken bones <div style="text-align: right;">TOTAL ____</div>	
SKIN		LUNGS			
<input type="checkbox"/> Acne <input type="checkbox"/> Hives, rashes <input type="checkbox"/> Dry skin <input type="checkbox"/> Bumps on back of arms <input type="checkbox"/> Flushing <input type="checkbox"/> Excessive sweating <div style="text-align: right;">TOTAL ____</div>		<input type="checkbox"/> Chest congestion <input type="checkbox"/> Asthma or bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <div style="text-align: right;">TOTAL ____</div>			
		ENERGY/SLEEP		WEIGHT	
IMMUNE				<input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> Weight loss (>5-10 lbs) <input type="checkbox"/> Weight gain (>5-10 lbs) <input type="checkbox"/> Fluid retention <div style="text-align: right;">TOTAL ____</div>	
<input type="checkbox"/> Colds <input type="checkbox"/> Flu <input type="checkbox"/> Chronic infections <div style="text-align: right;">TOTAL ____</div>		<input type="checkbox"/> Fatigue <input type="checkbox"/> Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Insomnia <input type="checkbox"/> Sleep disruptions <div style="text-align: right;">TOTAL ____</div>			

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