Center for Holistic Medicine

MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: ____ **DATE:** ____________________

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINTSCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACK	**Total:**

___ Nausea or vomiting ___ Diarrhea ___ Constipation ___ Bloated feeling ___ Heartburn
___ Bloated feeling ___ Intestinal/Stomach pain

EARS	**Total:**

___ Itchy ears Total ___ Earaches, ear infections ___ Drainage from ear
___ Ringing in ears, hearing loss

ENERGY/ACTIVITY	**Total:**

___ Mood swings ___ Anxiety, fear or Nervousness ___ Anger, irritability, or aggressiveness
__ Depression

EMOTIONS	**Total:**

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

EYES	**Total:**

___ Watery or itchy eyes ____ Swollen, reddened or sticky eyelids ___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or farsightedness)

HEAD	**Total:**

___ Headaches ___ Faintness ___ Dizziness ___ Insomnia

HEART	**Total**:

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

JOINTS/MUSCLE	**Total:**

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

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NAME: ____ **DATE:** __________________

POINTSCALE
2 = Never or almost never have the symptom
3 = Occasionally have it, effect is not severe

5 = Occasionally have, effect is severe
6 = Frequently have it, effect is not severe

7 = Frequently have it, effect is severe
8

LUNGS **Total:**

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

MIND **Total:**

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

MOUTH/THROAT **Total:**

___ Chronic coughing ___ Gagging frequent need to clear throat ___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips ___ Canker sores

NOSE **Total:**

___ Stuffy nose ___ Sinus problems ___ Hay fever ___ Sneezing attacks ___ Excessive mucus formation

SKIN **Total:**

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

WEIGHT **Total:**

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

OTHER **Total:**

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

Grand Total _________

Key to Questionnaire: Add individual scores and total each group. Add each group scores and give a grand total. Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100