HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

☐ Past month (New Patient) ☐ Past week (Follow-Up) ☐ Past 48 hours (Acute)

If you are a new patient then complete the questionnaire with the past month duration – **PLEASE ADD SCORES WHEN COMPLETE**

Point Scale: 0 – *Never or almost never* have the symptom. **1 –** *Occasionally* have it, effect in *not severe.* **2 –** *occasionally* have it, effect is *Severe.* **3 –** *Frequently* have it, effect is *not severe* **4 –** *Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD _____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **TOTAL** _____

EYES _____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **TOTAL** _____

EARS _____ Itchy Ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
TOTAL _____

NOSE _____ Stuffy Nose
_____ Sinus problems
_____ Hay Fever
_____ Sneezing attacks
_____ Excessive mucus formation
TOTAL _____

MOUTH/ THROAT _____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of invoice
_____ Swollen or discoloured tongue, gums, lips
_____ Canker Sores **TOTAL** _____

DIGESTIVE TRACK _____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL _____

JOINTS/ MUSCLE _____ Pains or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pains or aches in muscles
TOTAL _____

WEIGHT _____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating
TOTAL _____

ENERGY/ ACTIVITY _____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **TOTAL** _____

SKIN _____ Acne

_____ Hives, rashes, dry skin

_____ Hair Loss

_____ Flushing, hot flashes

_____ Excessive sweating **TOTAL** _____

HEART _____ Chest Pain

_____ Irregular or skipped heart beat

_____ Rapid or pounding heartbeat

TOTAL _____

LUNGS _____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing **TOTAL** _____

MIND _____ Poor Memory

_____ Confusion, poor concentration

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ Poor concentration

_____ Poor physical coordination

TOTAL _____

EMOTIONS _____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression **TOTAL** _____

OTHER _____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

TOTAL _____

GRAND TOTAL **TOTAL** _____

Please add up scores for each section when done.