

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 you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE

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 TRACT

Nausea or vomiting
 Diarrhea
 Constipation
 Bloating feeling
 Belching or passing gas
 Heartburn
 Intestinal/Stomach pain

Total _____

EARS

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

Total _____

EMOTIONS

Mood swings
 Anxiety, fear or nervousness
 Anger, irritability or aggressiveness
 Depression

Total _____

ENERGY/ACTIVITY

Fatigue, sluggishness
 Apathy, lethargy
 Hyperactivity
 Restlessness

Total _____

EYES

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

Total _____

HEAD

Headaches
 Faintness
 Dizziness
 Insomnia

Total _____

HEART

Irregular or skipped heartbeat
 Rapid or pounding heartbeat
 Chest pain

Total _____

JOINTS/MUSCLES

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

Total _____

LUNGS

Chest congestion
 Asthma, bronchitis
 Shortness of breath
 Difficult breathing

Total _____

MIND

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

Total _____

MOUTH/THROAT

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

Total _____

NOSE

Stuffy nose
 Sinus problems
 Hay fever
 Sneezing attacks
 Excessive mucus formation

Total _____

SKIN

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

Total _____

WEIGHT

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

Total _____

OTHER

Frequent illness
 Frequent or urgent urination
 Genital itch or discharge

Total _____

GRAND TOTAL _____

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100