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____

GENITOURINARY	NEUROLOGICAL	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