

**PATIENT HEALTH PROFILE - Multiple System Questionnaire (MSQ)**

<b>NAME</b>		
<b>DATE</b>		<b>EMAIL ADDRESS</b>

Rate each of the following symptoms based upon your typical health profile for the last **60 DAYS**:

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

<b>EXAMPLE:</b>	
Headaches	2
<b>HEAD</b>	
Headaches	
Faintness	
Dizziness	
Insomnia	
<b>Total for section</b>	
<b>EYES</b>	
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)	
<b>Total for section</b>	
<b>EARS</b>	
Itchy ears	
Earaches, ear infections	
Drainage from ear	
Ringing in ears, popping ears, hearing loss	
<b>Total for section</b>	
<b>NOSE</b>	
Stuffy nose	
Sinus problems	
Hay fever	
Sneezing attacks	
Excessive mucus formation	
<b>Total for section</b>	
<b>MOUTH/THROAT</b>	
Chronic coughing	
Gagging, frequent need to clear throat	
Sore throat, hoarseness, loss of voice	
Swollen or discolored tongue, gums, lips	
Canker sores	

<b>Total for section</b>	
<b>SKIN</b>	
Acne	
Hives, rashes, dry skin	
Hair loss	
Flushing	
Excessive sweating	
<b>Total for section</b>	
<b>HEART</b>	
Irregular or skipped heartbeat	
Rapid or pounding heartbeat	
Chest pain	
<b>Total for section</b>	
<b>LUNGS</b>	
Chest congestion	
Asthma, bronchitis	
Shortness of breath	
Difficulty breathing	
<b>Total for section</b>	
<b>DIGESTIVE TRACT</b>	
Nausea, vomiting	
Diarrhea	
Constipation	
Bloated feeling	
Belching, passing gas	
Heartburn, reflux	
Intestinal/stomach pain	
<b>Total for section</b>	
<b>JOINTS/MUSCLES</b>	
Pain or aches in joints	
Arthritis	
Stiffness or limitation of movement	
Pain or aches in muscles	
Feeling of weakness or tiredness	
<b>Total for section</b>	
<b>WEIGHT</b>	
Binge eating/drinking	
Craving certain foods	
Excessive weight	

Compulsive eating	
Water retention	
Underweight	
<b>Total for section</b>	
<b>ENERGY/ACTIVITY</b>	
Fatigue, tired, sluggish	
Apathy, lethargy	
Hyperactivity	
Restlessness	
<b>Total for section</b>	
<b>MIND</b>	
Poor memory	
Confusion, poor comprehension	
Poor concentration	
Poor physical coordination	
Difficulty in making decisions	
Stuttering or stammering	
Slurred speech	
Learning disabilities	
<b>Total for section</b>	
<b>EMOTIONS</b>	
Mood swings	
Anxiety/fear/nervousness	
Anger/irritability	
Panic attacks	
Depression	
<b>Total for section</b>	
<b>OTHER</b>	
Frequent illness	
Frequent or urgent urination	
Genital itch or discharge	
<b>Total for section</b>	
<b>GRAND TOTAL</b>	

<b>CGP/Practitioner Name</b>	
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