The Wellness Score™

Medical Symptoms Questionnaire (MSQ)

Name: ______________________________ Date: ____________

Email Address: ____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days.**

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

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
(does not include near or far-sighted)

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 Voice
_______ Swollen or Discolored Tongue, Gums, or Lips
_______ Canker Sores

Total _______

Skin

_______ Acne
_______ Hives, Rashes, Dry Skin
_______ Hair Loss
_______ Flushing, Hot Flashes
_______ Excessive Sweating

Total _______

Heart

_______ Irregular or Skipped Heartbeat
_______ Rapid or Pounding Heartbeat
_______ Chest Pain

Total _______

Lungs

_______ Chest Congestion
_______ Asthma, Bronchitis
_______ Shortness of Breath
_______ Difficulty Breathing

Total _______

Digestion

_______ Nausea, Vomiting
_______ Diarrhea
_______ Constipation
_______ Bloated Feeling
_______ Belching, Passing Gas
_______ Heartburn
_______ Intestinal/Stomach 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 _______

Weight

_______ Binge Eating/Drinking
_______ Craving Certain Foods
_______ Excessive Weight
_______ Compulsive Eating
_______ Water Retention
_______ Underweight

Total _______

Energy/ Activity

_______ Fatigue, Sluggishness
_______ Apathy, Lethargy
_______ Hyperactivity
_______ Restlessness

Total _______

Mind

_______ Poor Memory
_______ Confusion, Poor Comprehension
_______ Poor Concentration
_______ Poor Physical Condition
_______ Difficulty in Making Decisions
_______ Stuttering or Stammering
_______ Slurred Speech
_______ Learning Disabilities

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 _______