Multiple Symptom Questionnaire

Name: _____ Date: _____

Please use this scale to rate the frequency and severity of symptoms you have experienced in the past 6 months

0 = Never or almost never have the symptom

1 = Occasional and the effect is Mild
2 = Occasional and the effect is Severe
3 = Frequent and the effect is Mild
4 = Frequent and the effect is Severe

HEAD

1	Headache
	Faintness
	Dizziness
	Insomnia

Total **1**

NOSE

3	Stuffy nose
3	Sinus problems
	Hay fever
	Sneezing attacks
	Excessive mucus

Total **6**

MOUTH and THROAT

	Chronic coughing
	Gagging, throat clearing
	Sore throat, hoarseness
	Swollen tongue or discolored
	Tooth, gum or jaw pain
	Canker sores

Total **0**

SKIN

	Acne
	Hives or breakout
	Rash or dry skin
1	Hair loss
	Flushing or hot flashes
	Frequently feel cold
	Excessive sweating
	Numbness

Total **1**

HEART and LUNGS

	Irregular or heartbeat
	Pounding heartbeat
	Chest pain
	Chest congestion
	Asthma, bronchitis
	Shortness of breath
	Difficulty breathing

Total **0**

WEIGHT

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

Total **2**

DIGESTION

3	Nausea or vomiting
	Diarrhea
	Constipation
2	Bloated feeling
3	Belching, burping
	Passing gas, flatulence
3	Heartburn
	Pain in GI Tract

Total **11**

JOINTS AND MUSCLES

3	Pain or aches in joints
	Arthritis
3	Stiffness
	limitation of movement
3	Pain or aches in muscles
	Tremor or restless leg
3	Weakness or tiredness

Total **12**

ENERGY

4	Fatigue, sluggishness
	Apathy, lethargy
	Hyperactivity
3	Restlessness

Total **7**

MIND

	Poor memory
	Confusion
1	Poor comprehension
3	Poor concentration or focus
	Poor physical coordination
	Difficulty in making decisions
	Stuttering or stammering
	Learning disabilities

Total **4**

MOOD

	Mood swings
3	Anxiety, fear, nervousness
	Anger, irritability
	Aggressiveness
	Depression
	Other mood challenges

Total **3**

OTHER

Type In the Boxes Below

Total **0**

GRAND TOTAL **47**