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

_____ Headache
_____ Faintness
_____ Dizziness
_____ Insomnia

Total **0**

NOSE

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

Total **0**

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
_____ Hair loss
_____ Flushing or hot flashes
_____ Frequently feel cold
_____ Excessive sweating
_____ Numbness

Total **0**

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
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total **0**

DIGESTION

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

Total **0**

JOINTS AND MUSCLES

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

Total **0**

ENERGY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total **0**

MIND

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

Total **0**

MOOD

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

Total **0**

OTHER

Type In the Boxes Below

_____ [ ]
_____ [ ]
_____ [ ]
_____ [ ]
_____ [ ]
_____ [ ]
_____ [ ]

Total **0**

GRAND TOTAL **0**