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