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____

| NEURO | GENITOURINARY | 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 |