

# Multiple Symptom Health Questionnaire

NAME \_\_\_\_\_

DATE \_\_\_\_\_

WEEK \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:

Past 7 days

<b>Point Scale</b>	0 <i>Never or almost never</i> have the symptom	3	Frequently have it, effect is <i>not severe</i>
	1 <i>Occasionally</i> have it, effect is <i>not severe</i>	4	Frequently have it, effect is <i>severe</i>
	2 <i>Occasionally</i> have it, effect is <i>severe</i>		

**HEAD** \_\_\_\_\_

\_\_\_\_\_ Headaches

\_\_\_\_\_ Faintness

\_\_\_\_\_ Dizziness

\_\_\_\_\_ Insomnia

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**DIGESTIVE** \_\_\_\_\_

\_\_\_\_\_ Nausea, vomiting

**TRACT** \_\_\_\_\_

\_\_\_\_\_ Diarrhea

\_\_\_\_\_ Constipation

\_\_\_\_\_ Bloating feeling

\_\_\_\_\_ Belching, passing gas

\_\_\_\_\_ Heartburn

\_\_\_\_\_ Intestinal/stomach pain

\_\_\_\_\_ 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-sightedness)

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**JOINTS /** \_\_\_\_\_

**MUSCLE** \_\_\_\_\_

\_\_\_\_\_ Pain or aches in joints

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Stiffness or limitation of movement

\_\_\_\_\_ Pain or aches in muscles

\_\_\_\_\_ Feeling of weakness or tiredness

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**EARS** \_\_\_\_\_

\_\_\_\_\_ Itchy ears

\_\_\_\_\_ Earaches, ear infections

\_\_\_\_\_ Drainage from ear

\_\_\_\_\_ Ringing in ears, hearing loss

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**WEIGHT** \_\_\_\_\_

\_\_\_\_\_ Binge eating/drinking

\_\_\_\_\_ Craving certain foods

\_\_\_\_\_ Excessive weight

\_\_\_\_\_ Compulsive eating

\_\_\_\_\_ Water retention

\_\_\_\_\_ Underweight

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**NOSE** \_\_\_\_\_

\_\_\_\_\_ Stuffy nose

\_\_\_\_\_ Sinus problems

\_\_\_\_\_ Hay fever

\_\_\_\_\_ Sneezing attacks

\_\_\_\_\_ Excessive mucus formation

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**ENERGY /** \_\_\_\_\_

**ACTIVITY** \_\_\_\_\_

\_\_\_\_\_ Fatigue, sluggishness

\_\_\_\_\_ Apathy, lethargy

\_\_\_\_\_ Hyperactivity

\_\_\_\_\_ Restlessness

\_\_\_\_\_ 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

\_\_\_\_\_

**MIND** \_\_\_\_\_

\_\_\_\_\_ Poor memory

\_\_\_\_\_ Confusion, poor comprehension

\_\_\_\_\_ Poor concentration

\_\_\_\_\_ Poor physical coordination

\_\_\_\_\_ Difficulty in making decisions

\_\_\_\_\_ Stuttering or stammering

\_\_\_\_\_ Slurred speech

\_\_\_\_\_ Learning disabilities

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**SKIN** \_\_\_\_\_

\_\_\_\_\_ Acne

\_\_\_\_\_ Hives, rashes, dry skin

\_\_\_\_\_ Hair loss

\_\_\_\_\_ Flushing, hot flashes

\_\_\_\_\_ Excessive sweating

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**EMOTIONS** \_\_\_\_\_

\_\_\_\_\_ Mood swings

\_\_\_\_\_ Anxiety, fear, nervousness

\_\_\_\_\_ Anger, irritability, aggressiveness

\_\_\_\_\_ Depression

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**HEART** \_\_\_\_\_

\_\_\_\_\_ Irregular or skipped heartbeat

\_\_\_\_\_ Rapid or pounding heartbeat

\_\_\_\_\_ Chest pain

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**OTHER** \_\_\_\_\_

\_\_\_\_\_ Frequent illness

\_\_\_\_\_ Frequent or urgent urination

\_\_\_\_\_ Genital itch or discharge

\_\_\_\_\_ TOTAL

\_\_\_\_\_

**LUNGS** \_\_\_\_\_

\_\_\_\_\_ Chest congestion

\_\_\_\_\_ Asthma, bronchitis

\_\_\_\_\_ Shortness of breath

\_\_\_\_\_

**GRAND TOTAL** \_\_\_\_\_