MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

Big Picture Health

Name: _____ Date: _____

This questionnaire helps us identify the underlying cause of illness and allows us to track your progress over time.
Please rate each of the following symptoms based on your health profile over the past:

☐ Past 30 days (if first time completing MSQ) ☐ Past 48 hours (if completing a follow-up MSQ)

POINT SCALE:
0 – Never or almost never have symptoms
1 – occasionally have it, not severe
2 – occasionally have it, severe
3 – Frequently have it, not severe
4 – Frequently have it, severe

HEAD
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia
- ☐ **Total**

HEART
- ☐ Irregular/skipped beats
- ☐ Rapid/pounding beats
- ☐ Chest Pain
- ☐ **Total**

ENERGY/ACTIVITY
- ☐ Fatigue/sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restless leg
- ☐ **Total**

EYES
- ☐ Water/itchy eyes
- ☐ Swollen, red/sticky eyelids
- ☐ Bags, dark circles
- ☐ Blurred/tunnel vision
- ☐ **Total**

LUNGS
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ **Total**

MIND
- ☐ Poor memory
- ☐ Confusion, poor comprehension
- ☐ Stuttering/stammering
- ☐ Poor coordination
- ☐ Difficulty making decisions
- ☐ Slurred speech
- ☐ Learning disabilities
- ☐ **Total**

EARS
- ☐ Itchy ears
- ☐ Earaches, infections
- ☐ Drainage from ear
- ☐ Ringing/ hearing loss
- ☐ **Total**

DIGESTIVE TRACT
- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Belching, passing gas
- ☐ Intestinal/stomach pain
- ☐ Heartburn
- ☐ **Total**

EMOTIONS
- ☐ Mood Swings
- ☐ Anxiety, fear, nervousness
- ☐ Anger, irritability, aggressiveness
- ☐ Depression
- ☐ **Total**

NOSE
- ☐ Stuffy Nose
- ☐ Sinus Problems
- ☐ Hay Fever
- ☐ Sneezing attacks
- ☐ Excessive Mucous
- ☐ **Total**

MOUTH/THROAT
- ☐ Chronic coughing
- ☐ Gagging/ throat clearing
- ☐ Sore throat, hoarseness
- ☐ Swollen/discolored tongue, gums, lips
- ☐ Canker sores
- ☐ **Total**

JOINTS/MUSCLE
- ☐ Pain or aches in joints
- ☐ Arthritis
- ☐ Stiffness/limited movement
- ☐ Pain/aches in muscles
- ☐ Feeling of weakness or tiredness
- ☐ **Total**

SKIN	WEIGHT	OTHER
☐ Acne	☐ Binge eating/drinking	☐ Frequent illness
☐ Hives, rashes, dry skin	☐ Craving certain foods	☐ Frequent or urgent urination
☐ Hair loss	☐ Excessive weight	☐ Genital itch or discharge
☐ Flushing, hot flashes	☐ Compulsive eating	☐ **Total**
☐ Excessive sweating	☐ Water retention	
☐ **Total**	☐ Underweight	
	☐ **Total**	☐ **MSQ TOTAL**

Reviewed by: _____ Date: _____

Thank you for taking the time to complete this before your appointment. Please email or mail this form to me so I have it at least two business days before your appointment. This will allow me time to review your history so we can focus on you and your plan instead of using your appointment time to fill in this information.

Email to: tracey@bigpicturehealth.com (be certain to fill in all blanks and save the document before attaching to an email)

Mail to: Tracey Long
1046 Carousel Ln
Hendersonville, NC 28792

Thank you for trusting me to be part of your healthcare team.

Tracey

Add any comments or concerns below.