MSQ = METABOLIC SCREENING QUESTIONNAIRE

Patient Name _____ Date_____

Rate each of the following according to a scale of 0 to 4 based on your symptoms in the last 30 days.
Scale: 0 = Never or almost never
1 = Occasionally, but symptoms are not severe
2 = Frequently, but symptoms are not severe
3 = Occasionally, but the symptoms are severe
4 = Frequently and the symptoms are severe

Head		Mouth/throat	
Headaches	___	Chronic coughing	___
Faintness	___	Need to clear throat, feeling of mucus	___
Dizziness	___	Sore throat, hoarseness, loss of voice	___
Insomnia	___	Swollen or discolored tongue, gums, lip s	___
Total	____	Canker sores	___
		Total	____
Eyes		Skin	
Watery or itchy eyes	___	Acne	___
Dark circles under eyes	___	Hives, rashes	___
Swollen, reddened or sticky eyelids	___	Dry skin	___
Bags under eyes	___	Hair loss	___
Blurred or tunnel vision	___	Flushing, hot flashes	___
Total	____	Excessive sweating	___
		Total	____
Ears		Heart	
Itchy ears	___	Irregular heartbeat	___
Earaches, ear infections	___	Skipped heartbeat	___
Drainage from ear	___	Rapid or pounding heartbeat	___
Hearing loss	___	Chest Pain	___
Total	____	Total	____
Nose		Lungs	
Stuffy nose	___	Chest congestion	___
Sinus problems	___	Asthma, bronchitis	___
Hay fever	___	Shortness of breath	___
Sneezing attacks	___	Difficulty breathing	___
Excessive mucus formation	___	Total	____
Total	____		
Digestive tract		Emotions	
Nausea, vomiting	___	Mood swings	___
Difficulty swallowing	___	Anxiety, fear, nervousness	___
Diarrhea	___	Anger, irritability, aggressiveness	___
Constipation	___	Depression	___
Bloated feeling	___	Total	____
Belching, passing gas	___		
Heartburn	___		

Intestinal/stomach pain ___
Total ____

Joints/Muscles
Pain or aches in joint ___
Arthritis ___
Stiffness or limitation of movement ___
Pain or aches in muscles ___
Feeling of weakness or tiredness ___
Total ____

Other
Frequent illness ___
Frequent urination ___
Genital itch or discharge ___
Total ____

Weight
Binge eating/drinking ___
Craving certain foods ___
Excessive weight ___
Compulsive eating ___
Water retention ___
Underweight ___
Total ____

Other symptoms / General symptoms
Feeling cold, less tolerance for cold ___
Lower body temperature ___
Less sweating ___
Loss of appetite ___
Premenstrual disorders ___
Total ____

Energy/Activity
Fatigue, sluggishness ___
Apathy, lethargy ___
Hyperactivity ___
Restlessness ___
Total ____

Weight when answering [kg] _____
a year ago [kg] _____
Height [cm] _____
Waist circumference [cm] _____
Morning temperature
from armpit [°C] _____

Mind
Poor memory ___
Confusion, poor comprehension ___
Poor concentration ___
Poor physical co-ordination ___
Difficulty in making decisions ___
Stuttering, stammering,
slurred speech ___
Learning disabilities ___
Total ____