Health Symptoms Questionnaire (HSQ)

Patient Name _____
Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 - *Never or almost never* have the symptom

1 - *Occasionally* have it, effect is *not severe*

2 - *Occasionally* have it, effect is *severe*

3 - *Frequently* have it, effect is not severe

4 - *Frequently* have it, effect is severe

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision

Total _____

(Does not include near or far-sighted)

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing Attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips

_____ Canker Sores Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain Total _____

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight

Medical Symptoms Questionnaire (MSQ)

_____ Compulsive eating

_____ Water retention

_____ Underweight Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness Total _____

MIND

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities Total _____

EMOTIONS

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression Total _____

OTHER

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch Total _____

Grand Total _____