

# MSQ - Metabolic Symptoms Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

**Point Scale: 0-4 with (0 for no, 4 for yes)**

**0 = never, absent, not true    4 = always, constant, very true**

Brain	<input type="checkbox"/> My memory is declining <input type="checkbox"/> Difficulty remembering names <input type="checkbox"/> Difficulty focusing <input type="checkbox"/> Harder to learn new things <input type="checkbox"/> Difficulty remembering appointments <input type="checkbox"/> Temperament getting worse <input type="checkbox"/> Losing my attention span <input type="checkbox"/> I fatigue when driving <input type="checkbox"/> I walk into a room and forget why <input type="checkbox"/> I pick up my cell phone and forget why <div style="text-align: right;">/40</div>	Large Intestine	<input type="checkbox"/> Feeling that bowels don't empty completely <input type="checkbox"/> Lower abdominal pain, relief by passing stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hard, dry or small stool <input type="checkbox"/> Coated tongue <input type="checkbox"/> Foul smelling gassiness <input type="checkbox"/> More than 3 bowel movements per day <input type="checkbox"/> Pain or fullness below naval <input type="checkbox"/> Anus itches <div style="text-align: right;">/40</div>
Adrenal (High)	<input type="checkbox"/> Cannot fall asleep <input type="checkbox"/> Perspire easily <input type="checkbox"/> Under high amounts of stress <input type="checkbox"/> Weight gain when under stress <input type="checkbox"/> Wake up tired even after a full nights sleep <input type="checkbox"/> Chronic low back pain <input type="checkbox"/> Tend to be keyed up, can't calm down <input type="checkbox"/> Tend to be a night person <input type="checkbox"/> Clench or grind teeth <input type="checkbox"/> Allergies or hives <div style="text-align: right;">/40</div>	Stomach	<input type="checkbox"/> Belching or burping <input type="checkbox"/> Gas immediately after meal <input type="checkbox"/> Offensive breath <input type="checkbox"/> Sense of fullness during and after meals <input type="checkbox"/> Difficulty digesting fruits and veggies <input type="checkbox"/> Undigested food in stools <input type="checkbox"/> Pain, burning shortly after eating <input type="checkbox"/> Heartburn or acid reflux <input type="checkbox"/> Feel hungry and hour or two after eating <input type="checkbox"/> Loss of taste for meat <div style="text-align: right;">/40</div>
Adrenal (Low)	<input type="checkbox"/> Cannot stay asleep <input type="checkbox"/> Crave salt or salty foods <input type="checkbox"/> Slow starter in the morning <input type="checkbox"/> Afternoon fatigue <input type="checkbox"/> Dizziness with standing quickly <input type="checkbox"/> Afternoon headaches <input type="checkbox"/> Blood pressure low <input type="checkbox"/> Knee pain <input type="checkbox"/> Sensitivity to sunlight, need sunglasses <input type="checkbox"/> Headache with exertion or stress <div style="text-align: right;">/40</div>	Biliary	<input type="checkbox"/> Greasy or high fat foods upset <input type="checkbox"/> Bloating or gas several hours after eating <input type="checkbox"/> Bitter, metallic taste in mouth <input type="checkbox"/> Itchy skin <input type="checkbox"/> Yellowing of eyes <input type="checkbox"/> Stool color varies from clay to brown <input type="checkbox"/> Reddened skin, palms <input type="checkbox"/> Dry or flaky skin or hair <input type="checkbox"/> History of gallbladder attacks or stones <input type="checkbox"/> Gallbladder removed (Y/N) <div style="text-align: right;">/40</div>

Pituitary	<input type="checkbox"/> Diminished sex drive <input type="checkbox"/> Increased sex drive <input type="checkbox"/> Menstrual disorders or lack of menstruation <input type="checkbox"/> Tolerance of sugars <input type="checkbox"/> Splitting type headaches <input type="checkbox"/> Early or delayed sexual development (Y/N) <input type="checkbox"/> Memory failing <input type="checkbox"/> Fat deposits around face and shoulders  /32	Small Intestine	<input type="checkbox"/> Fiber causes constipation <input type="checkbox"/> Indigestion and fullness <input type="checkbox"/> Pain, tenderness above naval <input type="checkbox"/> Increased gassiness <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> undigested food in stool <input type="checkbox"/> Greasy, poorly formed, foul stool <input type="checkbox"/> Mucous in stool  /32
Immune	<input type="checkbox"/> Runny, drippy or congested nose <input type="checkbox"/> Catch colds at change of seasons <input type="checkbox"/> Sensitive to change (diet, seasons, stress) <input type="checkbox"/> Never get sick <input type="checkbox"/> History of infections (sinus, bladder, ear, etc.) <input type="checkbox"/> You have a shopping bag of supplements <input type="checkbox"/> You can't take certain supplements <input type="checkbox"/> Your symptoms come and go  /32	Hypoglycemia	<input type="checkbox"/> Crave sweets <input type="checkbox"/> Irritable if meal is missed <input type="checkbox"/> Depend on coffee to get going <input type="checkbox"/> Lightheaded if meals are missed <input type="checkbox"/> Feel shaky or jittery <input type="checkbox"/> Agitated, easily upset, nervous <input type="checkbox"/> Blurred vision <input type="checkbox"/> Poor memory, forgetful  /32
Thyroid	<input type="checkbox"/> Tired, sluggish <input type="checkbox"/> Feel cold <input type="checkbox"/> Require excessive sleep to function <input type="checkbox"/> Weight gain <input type="checkbox"/> Gain weight easily <input type="checkbox"/> Constipation <input type="checkbox"/> Depression, lack of motivation <input type="checkbox"/> Morning headaches <input type="checkbox"/> Outer third of eyebrows thinning <input type="checkbox"/> Thinning of hair, losing hair <input type="checkbox"/> Dryness of skin or scalp <input type="checkbox"/> Mental Sluggishness  /48	Insulin Resistance	<input type="checkbox"/> Fatigue after meals <input type="checkbox"/> Crave sweets <input type="checkbox"/> Eating sweets does not relieve craving <input type="checkbox"/> Must have sweets after meal <input type="checkbox"/> Waist expanding compared to hips <input type="checkbox"/> Frequent urination <input type="checkbox"/> Increased thirst and hunger <input type="checkbox"/> Difficulty losing weight <input type="checkbox"/> Binge or uncontrolled eating <input type="checkbox"/> Sleepy in the afternoon <input type="checkbox"/> Family members with Diabetes <input type="checkbox"/> Abdominal (belly) fat  /48
Female (Cycling)	<input type="checkbox"/> Menstrual cycle length changes <input type="checkbox"/> Long cycle, greater than 32 days <input type="checkbox"/> Short cycle, less than 24 days <input type="checkbox"/> Pain and cramping during periods <input type="checkbox"/> Scanty blood flow <input type="checkbox"/> Heavy blood flow <input type="checkbox"/> Breast pain or swelling <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Irritable or depressed during cycle <input type="checkbox"/> Acne break outs <input type="checkbox"/> Facial hair growth <input type="checkbox"/> Hair loss or thinning  /48	Female (Menopause)	<input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Hot flashes <input type="checkbox"/> Mental foggiess <input type="checkbox"/> Disinterest in sex <input type="checkbox"/> Mood swings <input type="checkbox"/> Depression <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Shrinking breasts <input type="checkbox"/> Facial hair growth <input type="checkbox"/> Acne <input type="checkbox"/> Vaginal pain, dryness or itching  /44

Anemia	<input type="checkbox"/> General fatigue or tired feeling <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Muscle cramps or “charley horses” <input type="checkbox"/> Dizzy, faint, or unsteady <input type="checkbox"/> Blurred vision <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Poor endurance, fatigue quickly <input type="checkbox"/> Feel run down <input type="checkbox"/> Pale skin, lips, gums <input type="checkbox"/> Unusual cravings such as clay, ice <input type="checkbox"/> Insomnia <input type="checkbox"/> Nail shape changes / spoon shaped <input type="checkbox"/> Cracks / sores at corners of mouth <input type="checkbox"/> Progressive fatigue after stress or exertion <input type="checkbox"/> General weakness <input type="checkbox"/> Bouts of nausea <input type="checkbox"/> Dark circles under eyes <input type="checkbox"/> Mild yellowing of eyes and/or skin <input type="checkbox"/> Small red dots under the skin <input type="checkbox"/> Cold hands and feet <input type="checkbox"/> Irritable <input type="checkbox"/> Unusual bruising <input type="checkbox"/> Red, sore tongue <input type="checkbox"/> Ringing in ears	EFAs	<input type="checkbox"/> Dry Skin, Rough Skin <input type="checkbox"/> Heels cracked <input type="checkbox"/> Dry cracked finger tips <input type="checkbox"/> Dandruff <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Dry, frizzy, unmanageable hair <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Increased thirst <input type="checkbox"/> Bumps, “chicken skin” on backs of arms <input type="checkbox"/> Patches of “alligator skin” <input type="checkbox"/> Soft, brittle finger nails <input type="checkbox"/> Allergies <input type="checkbox"/> Difficulty with attention or focus <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Aggression or hostility <input type="checkbox"/> Irritability <input type="checkbox"/> Depression <input type="checkbox"/> General learning difficulties <input type="checkbox"/> Poor memory <input type="checkbox"/> Irregular heart rhythm <input type="checkbox"/> Muscle or joint pain, aches <input type="checkbox"/> Aspirin/Advil improve my symptoms <input type="checkbox"/> Fatigue <input type="checkbox"/> Diarrhea
Male (Prostate)	<input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Dribbling after urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain in the thighs or heels <input type="checkbox"/> Feeling of incomplete bowel emptying <input type="checkbox"/> Leg nervousness at night <input type="checkbox"/> Difficulty starting or stopping urine stream <input type="checkbox"/> Waking up at night to urinate	Male Hormones	<input type="checkbox"/> Decreased Libido <input type="checkbox"/> Decreased morning erections <input type="checkbox"/> Decreased fullness of erection <input type="checkbox"/> Difficulty maintaining erections <input type="checkbox"/> Mental fatigue <input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Episodes of depression <input type="checkbox"/> Muscle soreness <input type="checkbox"/> Decrease in physical stamina <input type="checkbox"/> Unexplained weight gain <input type="checkbox"/> Increased fat around chest and hips <input type="checkbox"/> Increased sweating <input type="checkbox"/> More emotional than in the past

How many alcohol drinks do you consume per week? \_\_\_\_\_      How many caffeine drinks do you have per day? \_\_\_\_\_  
 How often do you exercise each week? \_\_\_\_\_      How often do you eat out each week? \_\_\_\_\_

Thank You for taking the time to carefully consider and answer these questions!