Inver Grove chiropractic

8 weeks to wellness
Give us 8 weeks and we'll change the rest of your life®

The Wellness Score

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 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** _____	**Energy/ Activity** _____ Fatigue, Sluggishness _____ Apathy, Lethargy _____ Hyperactivity _____ Restlessness **Total** _____	**Lungs** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing **Total** _____
Eyes _____ Watery or Itchy Eyes _____ Swollen, Reddened or Sticky Eye-lids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (does not include near or far-sightedness) **Total** _____	**Weight** _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight **Total** _____	**Digestion** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal/Stomach Pain **Total** _____
Ears _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss **Total** _____	**Heart** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain **Total** _____	**Nose** _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus **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 Condition _____ Difficulty in Making Decisions _____ Stuttering or Stammering _____ Slurred Speech _____ Learning Disabilities **Total** _____	**Joints/Muscles** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limitation of Movement _____ Pain or Aches in Muscles _____ Feeling of Weakness or Tiredness **Total** _____
Emotions _____ Mood Swings _____ Anxiety, Fear, Nervousness _____ Anger, Irritability, Aggressiveness _____ Depression **Total** _____	**Skin** _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating **Total** _____	**Other** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge **Total** _____ **Grand Total** _____

On a scale of 0 to 10 with 0 = WORST 10 = BEST, rate how well you think you are doing with the following:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____