

Medical Symptoms Questionnaire (MSQ) and Chronic Ailment Assessment Booklet (CAAB)

Please complete this booklet based upon your health profile over the last 30 days. Upon completion, return to your practitioner for evaluation. Your practitioner will review your responses and then discuss lifestyle changes and medical interventions as well as dietary supplements that may support those changes and interventions. Dietary supplements alone are not intended to diagnose, treat, or cure any disease.

Thank you.

Name: _____

Date: _____

Reassess Date: _____

MSQ AND CAAB HAVE BEEN CREATED BY AND USED WITH PERMISSION FROM THE INSTITUTE FOR FUNCTIONAL MEDICINE (IFM).

MSQ HAS BEEN USED FOR 20 YEARS BY PRACTITIONERS TO IDENTIFY THE BODY'S BURDEN LEVEL FOR TOXICITY. IT IS AN EXCELLENT MEANS TO EVALUATE THE NEED FOR A COMPREHENSIVE DETOXIFICATION PROGRAM OF HEALTH.

CAAB HAS BEEN UTILIZED FOR OVER 15 YEARS AND ALLOWS FOR THE IDENTIFICATION OF CHALLENGES IN VARIOUS ORGAN SYSTEMS IN THE BODY AND HELPS PRACTITIONERS MAKE MORE TARGETED RECOMMENDATIONS TO SUPPORT THE BODY.



Medical Symptoms Questionnaire

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 = Frequently have it, effect is not severe

3 = Occasionally have it, effect is severe

4 = Frequently have it, effect is severe

Digestive Tract	☐ Nausea or vomiting ☐ Diarrhea ☐ Constipation ☐ Bloating Feeling ☐ Belching or passing gas ☐ Heartburn	Total 	Lungs	☐ Chest congestion ☐ Asthma, bronchitis ☐ Shortness of breath ☐ Difficulty breathing	Total
Ears	☐ Itchy ears ☐ Ear aches, ear infections ☐ Drainage from ears ☐ Ringing in ears, hearing loss	Total 	Mind	☐ Poor memory ☐ Confusion, poor comprehension ☐ Difficulty in making decisions ☐ Stuttering or stammering ☐ Slurred speech ☐ Learning disabilities	Total
Emotions	☐ Mood swings ☐ Anxiety, fear, or nervousness ☐ Anger, irritability, or aggressiveness ☐ Depression	Total 	Mouth/Throat	☐ Chronic coughing ☐ Gagging frequently; need to clear throat ☐ Sore throat, hoarseness, loss of voice ☐ Swollen/discolored tongue/gums/lips ☐ Canker sores	Total
Energy & Activity	☐ Fatigue, sluggishness ☐ Apathy, lethargy ☐ Hyperactivity ☐ Restlessness	Total 	Nose	☐ Stuffy nose ☐ Sinus problems ☐ Hay fever ☐ Sneezing attacks ☐ Excessive mucus formation	Total
Eyes	☐ Watery or itchy eyes ☐ Swollen, reddened or sticky eyelids ☐ Bags or dark circles under eyes ☐ Blurred or tunnel vision (does not include near or far sightedness)	Total 	Skin	☐ Acne ☐ Hives, rashes, or dry skin ☐ Hair loss ☐ Flushing or hot flashes ☐ Excessive sweating	Total
Head	☐ Headaches ☐ Faintness ☐ Dizziness ☐ Insomnia	Total 	Weight	☐ Binge eating ☐ Craving certain foods ☐ Excessive weight ☐ Compulsive eating ☐ Water retention ☐ Underweight	Total
Heart	☐ Irregular or skipped heartbeat ☐ Rapid or pounding heartbeat ☐ Chest pain	Total 	Other	☐ Frequent illness ☐ Frequent or urgent urination ☐ Genital itch or discharge	Total
Joint & Muscles	☐ Pain or aches in joints ☐ Arthritis ☐ Stiffness or limitation of movement ☐ Pain or aches in muscles ☐ Feeling of weakness or tiredness	Total 	Grand Total 		

Chronic Ailment Assessment Booklet

CIRCLE the number which best describes the frequency of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the Total Point box. The score for YES is the number inside the parentheses ().

Key

- (0) never or rarely
- (1) twice a week or less
- (2) three to six times a week
- (3) daily or several times a day

PART I

Section A

- | | | | |
|---|---|---|------|
| 1) Have you taken a broad spectrum antibiotic drug: | | | |
| A) in the last 6 months | N | Y | (10) |
| B) If the response to A is no, have you ever taken antibiotics? | N | Y | (5) |
| 2) Have you had recurrent infections requiring prolonged antibiotic use? | N | Y | (20) |
| 3) Have you taken birth control pills? | N | Y | (5) |
| 4) Have you taken prednisone? | N | Y | (5) |
| 5) Have you had athlete's foot, ringworm, jock itch, or other chronic fungus infections of the skin or nails? | N | Y | (5) |
| 6) Do you crave sugar? | N | Y | (5) |
| 7) Do you crave breads? | N | Y | (5) |
| 8) Do you crave alcoholic beverages? | N | Y | (5) |
| 9) Have you ever had candida/yeast? | N | Y | (10) |
| 10) Endometriosis or infertility | N | Y | (5) |
| 11) Symptoms worse on damp, muggy days or in moldy places | 0 | 1 | 2 3 |
| 12) Fatigue or lethargy | 0 | 1 | 2 3 |
| 13) Poor memory | 0 | 1 | 2 3 |
| 14) Depression | 0 | 1 | 2 3 |
| 15) Muscle and or joint aches or weakness | 0 | 1 | 2 3 |
| 16) Abdominal pain | 0 | 1 | 2 3 |
| 17) Constipation | 0 | 1 | 2 3 |
| 18) Diarrhea | 0 | 1 | 2 3 |
| 19) Bloating, belching, or intestinal gas | 0 | 1 | 2 3 |
| 20) Vaginal burning, itching, or discharge | 0 | 1 | 2 3 |
| 21) Premenstrual tension | 0 | 1 | 2 3 |
| 22) Irritability | 0 | 1 | 2 3 |
| 23) Inability to concentrate | 0 | 1 | 2 3 |
| 24) Frequent mood swings | 0 | 1 | 2 3 |
| 25) Recurrent rashes or itching | 0 | 1 | 2 3 |
| 26) Rectal itching | 0 | 1 | 2 3 |
| 27) Urgency or urinary frequency | 0 | 1 | 2 3 |
| 28) Burning while urinating | 0 | 1 | 2 3 |

Total Points

Section B

- | | | | |
|---|---|---|------|
| 1) Have you traveled outside the USA? | N | Y | (5) |
| 2) Since traveling abroad, have you had an elevated white blood count, intestinal problems, night sweats, or unexplained fever? | N | Y | (5) |
| 3) Do you drink untested or unfiltered water? | N | Y | (5) |
| 4) Do you use a microwave oven for cooking (instead of reheating) beef, fish, or pork? | N | Y | (5) |
| 5) Do you prefer fish or meat that is under cooked, i.e., rare or medium rare? | N | Y | (5) |
| 6) At home, do you use the same cutting board for chicken, fish, and meat as you do for vegetables? | N | Y | (5) |
| 7) Have you lived with, or do you currently live with or handle pets? | N | Y | (5) |
| 8) Do you work or have children in a day care center? | N | Y | (5) |
| 9) Do you garden or work in a yard to which cats and dogs have access? | N | Y | (5) |
| 10) Have you ever had parasites? | N | Y | (10) |
| 11) Red blood in stool | 0 | 1 | 2 3 |
| 12) Abdominal pain and cramps | 0 | 1 | 2 3 |
| 13) Lower back pain | 0 | 1 | 2 3 |
| 14) Gas, bloating | 0 | 1 | 2 3 |
| 15) Fever | 0 | 1 | 2 3 |
| 16) Chronic fatigue | 0 | 1 | 2 3 |
| 17) Constipation | 0 | 1 | 2 3 |
| 18) Diarrhea | 0 | 1 | 2 3 |
| 19) Foul smelling stools | 0 | 1 | 2 3 |
| 20) Anal itching | 0 | 1 | 2 3 |
| 21) Bad breath | 0 | 1 | 2 3 |
| 22) Grind teeth | 0 | 1 | 2 3 |
| 23) Lethargic | 0 | 1 | 2 3 |
| 24) Mucus in stool | 0 | 1 | 2 3 |
| 25) Lack of stamina | 0 | 1 | 2 3 |

Total Points

Part II
Section A

1) Indigestion	0 1 2 3
2) Belching, burping	0 1 2 3
3) Gas immediately following a meal	0 1 2 3
4) Sense of fullness during meals	0 1 2 3
5) Poor appetite, picky eater	0 1 2 3
6) Difficult bowel movements	0 1 2 3
7) Difficulty swallowing	0 1 2 3
8) History of anemia, unresponsive to iron	0 1 2 3
9) Vegetarian (no eggs, dairy)	0 1 2 3
10) Spoon-shaped nails	0 1 2 3
11) Unintentional weight loss	0 1 2 3
12) Partial loss of taste or smell	0 1 2 3

Total Points

Section B

1) Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3
2) Pain, tenderness, soreness on left side under rib cage	0 1 2 3
3) Bloating	0 1 2 3
4) Excessive passage of gas	0 1 2 3
5) Abdominal cramps, aches	0 1 2 3
6) Nausea and/or vomiting	0 1 2 3
7) Specific foods/beverages aggravate indigestion	0 1 2 3
8) Roughage and fiber causes constipation	0 1 2 3
9) Three or more large bowel movements daily	0 1 2 3
10) Alternating constipation and diarrhea	0 1 2 3
11) Undigested food in stool	0 1 2 3
12) Mucus in stool	0 1 2 3
13) Dry, flaky skin; dry-brittle hair	0 1 2 3
14) Difficulty gaining weight	0 1 2 3

Total Points

Section C

1) Lower abdominal pain, cramping and/or spasms.	0 1 2 3
2) Lower abdominal pain relief by passing stool or gas	0 1 2 3
3) Raw fruits, vegetables, and stress aggravate bowel pain	0 1 2 3
4) Diarrhea (loose watery stool)	0 1 2 3
5) More than three bowel movements a day	0 1 2 3
6) Excessive gas and bloating	0 1 2 3
7) Painful, difficult, straining during bowel movements	0 1 2 3
8) Hard, dry, or small stools	0 1 2 3
9) Alternating diarrhea/constipation	0 1 2 3
10) Mucus, pus in stool	0 1 2 3
11) Feeling that bowels do not empty completely	0 1 2 3
12) Bright red blood following bowel movement	0 1 2 3
13) Anal itching	0 1 2 3

Total Points

Section D

1) Stomach pain, burning, aching 1-4 hours after eating	0 1 2 3
2) Feeling hungry an hour or two after eating	0 1 2 3
3) Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0 1 2 3
4) Heartburn, especially when lying down, bending forward	0 1 2 3
5) Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0 1 2 3
6) Difficulty or pain when swallowing	0 1 2 3
7) Chest pain or infections, difficulty breathing	0 1 2 3
8) For relief from carbonated beverages, cream/milk/food	0 1 2 3
9) Constipation	0 1 2 3
10) Black, tarry stool	0 1 2 3

Total Points

PART III
Section A

1) Moderate to severe pain under right side of rib cage	0 1 2 3	11) Feeling of poor health	0 1 2 3
2) Abdominal pain worsens with deep breathing	0 1 2 3	12) Fatigue, weakness, exhaustion	0 1 2 3
3) Regurgitate bitter fluid	0 1 2 3	13) Unable to concentrate, irritable, confused	0 1 2 3
4) Bloating, full feeling	0 1 2 3	14) Swollen feet and/or legs	0 1 2 3
5) Belching, heartburn, gas	0 1 2 3	15) Easy bruising	0 1 2 3
6) Fatty foods cause indigestion	0 1 2 3	16) Feeling of extreme dryness	0 1 2 3
7) Nausea or vomiting	0 1 2 3	17) Reddened skin, especially palms	0 1 2 3
8) Feel restless, agitated	0 1 2 3	18) Dark urine, diminished flow	0 1 2 3
9) Unexplained itchy skin worse at night	0 1 2 3	19) Dry, flaky skin, hair	N Y (3)
10) Stool color alternates from clay colored to normal brown	0 1 2 3	20) Yellowish cast to skin, eyes	N Y (3)

Total Points