



Name: _____

Age: _____

Assessment Date: _____

Symptom Tracker

Head <input type="checkbox"/> headaches <input type="checkbox"/> migraines <input type="checkbox"/> dizziness <input type="checkbox"/> faintness <input type="checkbox"/> trouble sleeping <p style="text-align: right;">Total: _____</p>	Mind <input type="checkbox"/> brain fog <input type="checkbox"/> poor memory <input type="checkbox"/> impaired coordination <input type="checkbox"/> difficulty deciding <input type="checkbox"/> slurred/stuttered speech <input type="checkbox"/> learning/attention deficit <p style="text-align: right;">Total: _____</p>	Eyes <input type="checkbox"/> swollen, red eyelids <input type="checkbox"/> dark circles <input type="checkbox"/> puffy eyes <input type="checkbox"/> poor vision <input type="checkbox"/> watery, itchy eyes <p style="text-align: right;">Total: _____</p>
Nose <input type="checkbox"/> nasal congestion <input type="checkbox"/> excessive mucus <input type="checkbox"/> stuffy/runny nose <input type="checkbox"/> sinus problems <input type="checkbox"/> frequent sneezing <p style="text-align: right;">Total: _____</p>	Ears <input type="checkbox"/> itchy ears <input type="checkbox"/> earaches, infections <input type="checkbox"/> drainage from ear <input type="checkbox"/> ringing, hearing loss <p style="text-align: right;">Total: _____</p>	Mouth/Throat <input type="checkbox"/> chronic cough <input type="checkbox"/> throat clearing <input type="checkbox"/> sore throat <input type="checkbox"/> swollen lips <input type="checkbox"/> canker sores <p style="text-align: right;">Total: _____</p>
Heart <input type="checkbox"/> irregular heartbeat <input type="checkbox"/> fast heart rate <input type="checkbox"/> chest pain <p style="text-align: right;">Total: _____</p>	Lungs <input type="checkbox"/> chest congestion <input type="checkbox"/> asthma, bronchitis <input type="checkbox"/> shortness of breath <input type="checkbox"/> difficulty breathing <p style="text-align: right;">Total: _____</p>	Skin <input type="checkbox"/> acne <input type="checkbox"/> hives <input type="checkbox"/> eczema, dry skin <input type="checkbox"/> hair loss <input type="checkbox"/> hot flashes <input type="checkbox"/> excessive sweating <p style="text-align: right;">Total: _____</p>
Weight <input type="checkbox"/> inability to lose weight <input type="checkbox"/> food cravings <input type="checkbox"/> overweight <input type="checkbox"/> underweight <input type="checkbox"/> compulsive eating <input type="checkbox"/> water retention/swelling <p style="text-align: right;">Total: _____</p>	Digestion <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> diarrhoea <input type="checkbox"/> constipation <input type="checkbox"/> bloating <input type="checkbox"/> belching/passing gas <input type="checkbox"/> heartburn/indigestion <input type="checkbox"/> stomach pain or cramp <p style="text-align: right;">Total: _____</p>	Emotions <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> mood swings <input type="checkbox"/> nervousness <input type="checkbox"/> easily irritated <p style="text-align: right;">Total: _____</p>
Energy/Activity <input type="checkbox"/> fatigue <input type="checkbox"/> lethargy <input type="checkbox"/> hyperactivity <input type="checkbox"/> restlessness <p style="text-align: right;">Total: _____</p>	Joint/Muscles <input type="checkbox"/> pain/aching joints <input type="checkbox"/> arthritis <input type="checkbox"/> muscle stiffness <input type="checkbox"/> pain/muscle aches <input type="checkbox"/> weakness/tiredness <p style="text-align: right;">Total: _____</p>	Other <input type="checkbox"/> frequent illness/infections <input type="checkbox"/> frequent/urgent urination <input type="checkbox"/> genital itch, discharge <p style="text-align: right;">Total: _____</p>

MSQ Total Score _____

