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.

MSQ

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 ___ Bloated 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***	___

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevent any disease.

CAAB

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