MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total 0

EARS

___ Itchy ears Total
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total 0

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression

Total 0

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total 0

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 0

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total 0

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total 0

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total 0

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total 0

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total 0

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total 0

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total 0

SKIN

___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total 0

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total 0

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total 0

GRAND TOTAL 0

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group scores and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

Ayurvedic VPK Vikruti Questionnaire

Please highlight/circle your answer for each row. Answer each question thinking about how you have been **over the last 3-4 months**. Do **not** chose your answer based on your **long term** state, childhood tendencies or habits. Total your responses at the end.

Anxious, overwhelmed, fearful, esp when stressed	Angry, aggressive, impatient, irritable, frustrated, esp when stressed	Sluggish thinking; procrastination
Scattered thoughts, difficult to focus	Argumentative, outbursts of temper	Depressed, apathetic; no desire
Worried, wired, overactive mind	Controlling	Over attachment; Clingy, hanging on to people/ideas; possessive
Insecure, shy, indecisive	Critical of self and others	Slow to comprehend and react
Impatient	Sense of failure	Difficult to accept change
Irregular appetite	Excessive hunger or thirst	Materialistic
Bloating, gas, burping	Headache/irritable/weak with hunger	Sentimental
Irritable bowel syndrome	Heartburn, indigestion	Grogginess all day; slow to move
Constipation	Acidic stomach, heartburn, ulcer	Very tired in the morning, hard to get out of bed; sluggish energy
Restless; tired body but can't relax	Frequent/loose/burning stools	Mucus, congestion in the chest/throat; prone to asthma
Insomnia; wake up at night and takes time to go back to sleep	Bad breath	Frequent colds, cough, allergies
General body aches; sharp pains	Rectal burning, hemorrhoids	Nausea
Muscle spasms, seizures	Sour body odor, excess perspiration	Poor appetite
Aching or arthritis; joint stiffness/pain	Hot flashes, night sweats	Sleepy after meals; sluggish digestion; food just 'sits' in stomach
Sensitive to cold food/drinks	Skin rashes, boils, inflammations, acne; oily skin	Prediabetic/diabetic
Nail biting	Prone to fevers	Weight gain, obesity
Rough, flaky skin, chapped skin, lips	Disturbed sleep	Edema, water retention, bloating
Heart palpitations; lightheadedness	Disturbing dreams	Heaviness in the limbs
Dry throat and eyes	Tendency to bloodshot eyes	Cyst and other growth
Weight loss	Problem with vision; difficult to "see" solutions to problems	Pale, cool and clammy skin
Intolerance to cold and wind/drafts	Intolerance or sensitive to heat	Intolerance to cold, damp weather

Total _____ **Total** _____ **Total** _____

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Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name_____ Date_____

Food Plan Type: _____

Day 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ **B/P/BL** ☐ W/T/BR
Mid-AM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ **B/P/BL** ☐ W/T/BR
Lunch **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ **B/P/BL** ☐ W/T/BR
Mid-PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ **B/P/BL** ☐ W/T/BR
Dinner **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ **B/P/BL** ☐ W/T/BR
PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ **B/P/BL** ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; O: Orange; Y: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; W/T/BR: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good **Relaxation** ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

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Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name_____ Date_____

Food Plan Type: _____

Day 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good **Relaxation** ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

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Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; O: Orange; Y: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; W/T/BR: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good Relaxation ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

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