Digestive Health Evaluation Survey

Rate each symptoms based upon how you have been feeling during the past 30 days

0 = **Never, almost never** 1 = **Occasionally**, yet **not severe** 2 = **Occasionally**, yet **severe** 3 = **Frequently**, yet **not severe** 4 = **Frequent, severe**

List A

Digestive Tract _____ **TOTAL**

_____ Nausea & vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching or passing gas
_____ Stomach pains or cramps
_____ Heartburn or GERD
_____ Blood or mucous in stools

Joints & Muscles _____ **TOTAL**

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness, limited movement
_____ Pain or aches in muscles
_____ Feeling weak or tired
_____ Swollen, tender joints

Weight _____ **TOTAL**

_____ Binge eating/drinking
_____ Food cravings
_____ Over weight
_____ Compulsive eating
_____ Water retention
_____ Under weight

Energy & Activity _____ **TOTAL**

_____ Apathy, lethargy
_____ Attention deficit
_____ Fatigue
_____ Hyperactivity
_____ Restlessness
_____ Poor physical coordination
_____ Sluggishness
_____ Slurred speech

Emotions _____ **TOTAL**

_____ Mood swings
_____ Anxiety, fear
_____ Angry, irritable
_____ Argumentative
_____ Frustrated, cries often
_____ Aggressive
_____ Nervous
_____ Depression

Mind _____ **TOTAL**

_____ Poor memory
_____ Difficulty completing tasks
_____ Difficulty with mathematics
_____ Difficulty with recalling information
_____ Poor/short attention span
_____ Confusion
_____ Easily distracted
_____ Difficulty making decisions
_____ Learning difficulties/disabilities
_____ Poor concentration

Other _____ **TOTAL**

_____ Frequent illness or slow recovery
_____ Frequent or urgent urination
_____ Genital/Rectal itching
_____ Ears canals itching
_____ Ringing in the ears

TOTAL LIST A _____

List B

_____ Moodiness
_____ Irritable, jittery
_____ Depressed
_____ Chronically fatigued

Head _____ **TOTAL**

_____ Headaches
_____ Dizziness

Skin _____ **TOTAL**

_____ Rashes/itchy skin

Digestive Tract _____ **TOTAL**

_____ Indigestion/fullness
_____ Constipation
_____ Foul smelling gas

Mouth _____ **TOTAL**

_____ Cold/canker sores
_____ Bad breath

Sinuses _____ **TOTAL**

_____ Post-nasal drip
_____ Cough or wheezing
_____ Nasal itching

Eyes _____ **TOTAL**

_____ Burning of eyes

Ears _____ **TOTAL**

_____ Ear pain/hearing loss
_____ Pressure in ears

Other _____ **TOTAL**

_____ Cravings for candy/sweets
_____ Vaginal/Rectal itching/discharge
_____ Irregular menses
_____ PMS
_____ Loss of sex drive

TOTAL LIST B _____

GRAND TOTAL (A + B) _____

Scoring Guide: Score > 10 for either List A or B, IgG Delayed Food Allergy testing is recommended. Score > 30 in List A, *Candida albicans* testing is recommended. If GRAND TOTAL score is > 50 , both IgG Delayed Food Allergy testing and *Candida albicans* testing is recommended.