Toxicity & Inflammation Questionnaire: General Signs and Symptoms

Client Name: _____ Date: _____

This questionnaire identifies signs and symptoms that can help your doctor address the underlying cause of your GI-related illnesses (toxins, inflammation, etc). This questionnaire is designed to be completed **before** and **after** the suggested protocol your doctor recommends for you. This will help your practitioner track your progress over time.

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

Head
__ Headaches
__ Dizziness
__ Insomnia
__ Faintness **____ Total**

Ears
__ Itchy ears
__ Ringing in ears/ loss of hearing
__ Earaches/ ear infections
__ Drainage from **____ Total**

Eyes
__ Bags or dark circles under eyes
__ Watery or itchy eyes
__ Swollen, reddened, or sticky eyelids
__ Blurred or tunnel vision (excluding near- or far- sightedness) **____ Total**

Nose
__ Stuffy nose
__ Sinus congestion, sinus infection
__Constant sneezing
__ Hay fever/ allergies
__ Excess mucus formation **____ Total**

Mouth/ Throat
__ Chronic coughing
__ Sore throat, hoarseness, loss of voice
__ Gagging, frequent need to clear throat
__ Swollen tongue, gums, or lips
__ Swollen lymph nodes
__ Canker sores, mouth ulcers **____ Total**

Heart
__ Chest pain
__ Irregular or skipped heartbeat
__ Rapid or pounding heartbeat **____ Total**

Lungs
__ Asthma, bronchitis
__ Chest congestion
__ Shortness of breath
__ Difficulty breathing **____ Total**

Skin
_ Acne or brown "age/liver spots"
__ Hives, rashes, cysts, boils
__ Eczema or psoriasis
__ Itchy skin/ dermatitis
__ Hair loss, hair thinning
__ Body odor
__ Excessive sweating ____ **Total**

Joints/Muscles
__ Pain or aches in joints or lower back
__ Stiffness or limitation of movement
__ Arthritis
__ Pain or aches in muscles ____ **Total**

Mental/Emotional
__ Poor memory
__ Difficulty concentrating
__ Mood swings
__ Depression
__ Anxiety, fear, or nervousness
__ Anger, irritability, or aggressiveness
__ Insomnia ____ **Total**

Energy Level
__ Fatigue/ low energy
__ Restlessness
__ Hyperactivity
__ Feeling of weakness ____ **Total**

Weight
__Underweight
__ Overweight
__ Difficulty losing weight
__ Crave certain foods ____ **Total**

Digestive Tract
__ Nausea, vomiting
__ Diarrhea
__ Constipation
__ Bloated feeling
__ Belching, passing gas
__ Heartburn
__ Intestinal/ stomach pain ____ **Total**

Other
__ PMS
__ Frequent colds, flus
__ Chemical or environmental sensitivities
__ Food allergies/ sensitivities ____ **Total**

Please add the numbers from each section and write the section total in the spaces provided, then add all the section totals together and put that total in the space below.

____ **Grand Total**

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