

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
- Bloating 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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