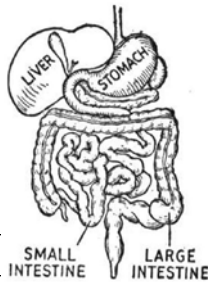


Name _____

Date ____/____/____



The Digestive System Questionnaire

This system has 60% of the immune system around it, excludes toxins, an, makes vitamins, digests food for nutrients, and houses many millions of bacteria. Nurture it to live well !

DESCRIPTION OF PRIMARY PROBLEM

When did it first begin? _____

When did it last occur? _____

About how often does it occur? ____ time(s) per week/month

About how long does it last? _____ minutes/hours/days

What helps cause it? _____

What(if any) is the sensation you notice before it begins? _____

The Original Incident

The last time(date) I can remember feeling really well for more than just a few days was _____

During the six-month period before the date I have just written down, I experienced (**check ("✓") all that apply**):

- A period of great stress
 - at home....._____
 - at work or school_____
 - in an important relationship....._____
- A major loss....._____
- A major triumph....._____
- An emotional trauma....._____
- An emotional breakthrough....._____
- A financial setback....._____
- An addition to my family....._____
- A new relationship....._____
- A change in sleeping habits....._____
- A change in location of my home, school, or workplace....._____
- Renovation / construction at home, work, school....._____
- A leak or flood at home, work, or school....._____
- "Food poisoning" or an "intestinal flu"_____
- A dental problem or major dental work _____
- Foreign travel....._____
- Wilderness activities_____
- An acute medical illness (for ex. an infection) _____
- Hospitalization....._____
- Surgery....._____
- An accident or injury....._____
- A new medication (example, taking an antibiotic) _____
- A change of diet....._____
- A crash or fad diet....._____
- A change in exercise or activity level....._____
- A change in my use of
 - nutritional supplements....._____
 - medication....._____
 - my soap, shampoo, or detergent....._____

Answer each question with a number, as follows:

- 0 = Never/Rare** – Insignificant **AND** Monthly or less often
- 1 = Occasionally or Slight** – Average 1x/wk **OR** Mildly affects you
- 2 = Often or Moderate** – 2-3 per week **OR** Moderately affects you
- 3 = Frequent or Severe** – Most days [or EVERY month like a cycle] **OR** Mild affects you
- ? = Unknown** – I don't understand or know
- NA** – Not Applicable

Hypoacidity

- Food repeats on you after you eat.....0 1 2 3
- Excessive burping and belching following meals.....0 1 2 3
- Stomach spasms and cramping during or after eating.0 1 2 3
- A sensation that food just sits in your stomach, creating uncomfortable fullness, pressure and bloating during or after a meal.....0 1 2 3
- Bad taste in your mouth.....0 1 2 3
- Small amounts of food fill you up immediately..... 0 1 2 3
- Skip meals or eat erratically because you have no appetite..... 0 1 2 3

Total _____

GI Inflammation

- Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt.....0 1 2 3
- Feel hungry an hour or two after eating a good-sized meal.....0 1 2 3
- Stomach pain, burning and/or aching over a period of 1-4 hours after eating.....0 1 2 3
- Stomach pain, burning and/or aching relieved by eating food, drinking carbonated beverage, cream or milk, or taking antacids..... 0 1 2 3
- Burning sensation in the lower part of your chest, especially when lying down or bending forward... 0 1 2 3
- Painful indigestion even when relaxed or on vacation.0 1 2 3
- Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache..... 0 1 2 3
- Feel a sense of nausea when you eat.....0 1 2 3
- Difficulty or pain when swallowing food or beverage.0 1 2 3

Total _____

Small Intestine, Pancreas

- When massaging under your rib cage *on your left* side, there is pain, tenderness or soreness..... 0 1 2 3
- Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal... 0 1 2 3
- Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement..... 0 1 2 3
- Specific foods/beverages aggravate indigestion..... 0 1 2 3
- The consistency or form of your stool changes (e.g., from narrow to loose) during one day.....0 1 2 3
- Stool odor is embarrassing.....0 1 2 3
- Undigested food in your stool..... 0 1 2 3
- Three or more large bowel movements daily..... 0 1 2 3
- Diarrhea (frequent loose, watery stool)..... 0 1 2 3
- Bowel movement shortly after eating (within 1 hour).0 1 2 3

Total _____

Colon

- Discomfort, pain or cramps in your colon
(lower abdominal area)..... 0 1 2 3
 - Emotional stress and/or eating raw fruits and
vegetables causes abdominal bloating, pain,
cramps or gas.....0 1 2 3
 - Generally constipated (or straining during
bowel movements).....0 1 2 3
 - Stool is small, hard and dry.....0 1 2 3
 - Pass mucous in your stool.....0 1 2 3
 - Alternate between constipation and diarrhea..... 0 1 2 3
 - Rectal pain, itching or cramping..... 0 1 2 3
 - No urge to have a bowel movement.....0 1 2 3
 - An almost continual need to have a bowel movement.0 1 2 3
- Total _____

LIVER/GALLBLDDER (related to intestines)

- When massaging under your rib cage on your
right side, there is pain, tenderness or soreness....0 1 2 3
 - Abdominal pain worsens with deep breathing.....0 1 2 3
 - Pain at night that may move to your back or
right shoulder.....0 1 2 3
 - Bitter fluid repeat after eating..... 0 1 2 3
 - Feel abdominal discomfort or nausea when eating
rich, fatty or fried foods0 1 2 3
 - Throbbing temples and/or-dull pain in forehead
associated with overeating.....0 1 2 3
 - Unexplained itchy skin worse at night 0 1 2 3
 - Stool color alternates from clay colored and
normal brown..... 0 1 2 3
 - General feeling of poor health.....0 1 2 3
- Total _____

Do you have food allergies?

- My ears turn red for no apparent reason..... 0 1 2 3
 - My tongue looks like a map, with irregular
flattened patches..... 0 1 2 3
 - I have dark circles under my eyes.....0 1 2 3
 - I have to clear my throat frequently..... 0 1 2 3
 - My lips or throat itch after eating.....0 1 2 3
 - My skin itches for no apparent reason..... 0 1 2 3
 - The inner corners of my eyes itch..... 0 1 2 3
 - I feel sleepy after eating.....0 1 2 3
 - I feel my best if I don't eat at all.....0 1 2 3
 - I feel more hungry after eating than before I ate... 0 1 2 3
 - I have irresistible cravings for specific foods..... 0 1 2 3
(milk, for example)_____
 - Eating gives me diarrhea, headaches, or skin rashes..... 0 1 2 3
- Total _____

If your total score is 5 or more, food allergy or food intolerance may be a trigger for symptoms.