Food and Chemical Sensitivity Survey

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the following food and chemical sensitivity questionnaire by placing a CHECK MARK next to the following symptom(s) that apply to you based upon your experience over the last 60 days. Place two check marks if the symptom is severe.

0-15 symptoms (mild intolerance), 16-30 (moderate Intolerance), 30-45 (severe intolerance)

Digestive Symptoms:

\_\_\_ Stomach pains and cramping

\_\_\_ Constipation

\_\_\_ Diarrhea

\_\_\_ Discolored Stool

\_\_\_ Reflux or Heartburn

\_\_\_ Bloating

\_\_\_ Gas

\_\_\_ Nausea or Vomiting

Weight:

\_\_\_ Inability to lose weight

\_\_\_ Food cravings

\_\_\_ Binge eating

\_\_\_ Water retention

Sinus/Respiratory:

\_\_\_Stuffy or runny nose

\_\_\_ Asthma

\_\_\_ Chest Congestion

\_\_\_ Chronic Cough

\_\_\_ Wheezing

\_\_\_ Frequent Sneezing

Eye/Throat:

\_\_\_ Itchy eyes

\_\_\_ Watery eyes

\_\_\_ Sore Throat

\_\_\_ Persistent canker sores

Emotional/Mental:

\_\_\_ Depression

\_\_\_ Anxiety

\_\_\_ Mood Swings

\_\_\_ Irritability

\_\_\_ Poor Concentration

**Total Score**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:**

Energy:

\_\_\_ Fatigue

\_\_\_ Hyperactivity

\_\_\_ Lethargy

\_\_\_ Restlessness

\_\_\_ Insomnia

Skin Disorders:

\_\_\_ Eczema

\_\_\_ Dermatitis

\_\_\_ Excessive Sweating

\_\_\_ Rashes

\_\_\_ Hives

Head/Ears:

\_\_\_ Migraines

\_\_\_ Headaches

\_\_\_ Earaches

\_\_\_ Ear Infection

\_\_\_ Ringing in the Ears

Other Symptoms:

\_\_\_ Joint Pain

\_\_\_ Arthritis

\_\_\_ Irregular Heartbeat

\_\_\_ Chest pains

\_\_\_ Muscle aches

Please List any other symptoms not mentioned above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phlebotomy Technician Notes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_