



Food and Chemical Sensitivity Survey

Date: ____/____/____ Patient Name _____
 Gender: **M / F** Height: _____ Weight: _____ lbs.

Please list all medications you are currently taking:

*Please complete the following food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last **60 days**. This survey should be taken again after the completion of the Food Sensitivity Testing Test, prior to reintroduction of "reactive" foods. Typically 3-6 months after initial testing. This comparison will help to assess the success of your eating modification program.*

Symptom Scoring System:

- 0 = No Symptoms**
- 1 = Experience Mild Symptoms**
- 2 = Experience Moderate Symptoms**
- 3 = Severe Symptoms**

Digestive Symptoms

- ____ Stomach Pains or Cramping
- ____ Constipation
- ____ Diarrhea
- ____ 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

Head/Ears

- ____ Migraines
- ____ Headaches
- ____ Earaches
- ____ Ear Infection
- ____ Ringing in Ears

Eyes/Throat

- ____ Itchy Eyes
- ____ Watery Eyes
- ____ Sore Throat
- ____ Persistent Canker Sores

Emotional/Mental

- ____ Depression
- ____ Anxiety
- ____ Mood Swings
- ____ Irritability
- ____ Poor Concentration

Energy

- ____ Fatigue
- ____ Hyperactivity
- ____ Lethargy
- ____ Restlessness
- ____ Insomnia

Skin Disorders

- ____ Eczema
- ____ Dermatitis
- ____ Excessive Sweating
- ____ Rashes
- ____ Hives

Other Symptoms:

- ____ Joint Pain
- ____ Arthritis
- ____ Irregular Heartbeat
- ____ Chest Pains
- ____ Muscle Aches

Please list any symptoms not mentioned above:

Total: ____/138 = ____