SYMPTOMATIC SCREENING QUESTIONAIRE

NAME _____ DATE _____

CIRCLE the number which best describes the frequency of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number on the Total Points line. The score for YES is the number inside the parenthesis ( ).

0 = never or rarely	1 = twice a week or less	2 = three to six times a week	3 = daily or several times a day

Section A- DIGESTION AND DYSBIOSIS

1. Bad breath	0 1 2 3
2. Bad body odour	0 1 2 3
3. Excessive belching, burping and/or bloating	0 1 2 3
4. Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3
5. Excessive gas and bloating	0 1 2 3
6. Abdominal cramping, aches and pains	0 1 2 3
7. Specific foods and beverages aggravate indigestion and cause bloating	0 1 2 3
8. Crave sugar/breads/sweets or alcohol	0 1 2 3
9. Rumbling noises after food	0 1 2 3
10. Gas immediately after meals	0 1 2 3
11. Roughage or fibre cause constipation	0 1 2 3
12. Stool - undigested food present	0 1 2 3
13. Stool - yellowish, foul smelling	0 1 2 3
14. Painful, difficult straining during bowel movements	0 1 2 3
15. Bright red blood following bowel movement	0 1 2 3
16. Frequent or urgent urination	0 1 2 3
17. Antibiotic use, 4 or more times/year	N Y (3)
18. Long-term antibiotic use, greater than 1 month	N Y (5)
19. On birth control pill more than 2 years	N Y (4)
20. Athlete's foot, ringworm or any chronic fungal infections of the skin or nails	N Y (4)

Total Points _____

Section B- LIVER FUNCTION & DETOXIFICATION

1. General feeling of poor health	0 1 2 3
2. Fatty foods cause indigestion	0 1 2 3
3. Feeling of extreme dryness	0 1 2 3
4. Dry, flaky skin and/or hair	0 1 2 3
5. Bags or dark circles under eyes	0 1 2 3
6. Deterioration of eyesight, spots	0 1 2 3
7. Yellowish colour of skin or eyes	0 1 2 3
8. Hives, rashes or itchy skin	0 1 2 3
9. Sinus problems	0 1 2 3
10. Excess mucous formation	0 1 2 3
11. Chronic coughing	0 1 2 3
12. Asthma, bronchitis	0 1 2 3
13. Sore throat, hoarseness, loss of voice	0 1 2 3
14. Swollen or discoloured tongue, gums or lips	0 1 2 3
15. Rapid or pounding heartbeat	0 1 2 3
16. Pain or aches in joints	0 1 2 3
17. Pains or aches in muscles	0 1 2 3
18. Headaches	0 1 2 3
19. History of migraines	0 1 2 3
20. Insomnia	0 1 2 3
21. Feel restless, agitated, angry	0 1 2 3
22. Anxious or depressed (mood swings)	0 1 2 3
23. Poor concentration and/or memory	0 1 2 3
24. Exposure to perfumes, tobacco smoke, exhaust fumes or other chemicals that provoke symptoms.	N Y (5)

Total Points _____

Section C- STRESS

Do You...

1. Have coffee, tea, tobacco, sugar or other stimulants as a pick-me-up	0 1 2 3
2. Do you suffer from Brain Fog, clouded thinking	0 1 2 3
3. Experience difficulty concentrating and thinking clearly	0 1 2 3
4. Feel irritable or oversensitive	0 1 2 3
5. Feel stressed, nervous or tense	0 1 2 3

In The Past Two Years, Have You Experienced...

6. Losing or starting work	N Y (3)
7. Moving house	N Y (3)
8. Bankruptcy	N Y (4)
9. Breaking the law	N Y (4)
10. Death in the family	N Y (4)
11. Separation from partner	N Y (4)
12. Divorce	N Y (5)

Total Points _____

Section D- VITALITY

Do You...

1. Do you wake up tired	0 1 2 3
2. Have difficulty staying awake	0 1 2 3
3. Often feel tired or overworked	0 1 2 3
4. Have inadequate energy or fatigue	0 1 2 3
5. Suffer from Chronic Fatigue Syndrome	0 1 2 3
6. Find it hard to get up or become motivated in the morning	0 1 2 3
7. Experience mental confusion or sluggishness	0 1 2 3

Total Points _____

Section E- WEIGHT MANAGEMENT

Where 0 is very satisfied and 3 is very concerned, please rate how you feel about...

1. The way my body looks	0 1 2 3
2. The way my body feels	0 1 2 3
3. My attractiveness	0 1 2 3
4. My present weight	0 1 2 3
5. My muscle tone	0 1 2 3
6. My fluid retention	0 1 2 3
7. My body fat	0 1 2 3
8. My strength	0 1 2 3
9. My endurance	0 1 2 3
10. My flexibility	0 1 2 3

Total Points _____