

Digestive/Detoxification Screening Questionnaire



Name: _____

Date: _____

Instructions for Part I (All Sections) and Part II (Section A): 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 section total line. The score for **YES** is the number inside the parenthesis ().

KEY: 0 = Rarely; 1 = 2x a week or less; 2 = 3x to 6x a week; 3 = daily

Part I

SECTION A			
1	Indigestion, "sour stomach"	0	1 2 3
2	Excessive belching, burping, and/or bloating	0	1 2 3
3	Gas immediately following a meal	0	1 2 3
4	Sense of fullness during and after meals	0	1 2 3
5	Poor appetite, disinterest in food	0	1 2 3
6	Difficult bowel movements	0	1 2 3
7	Difficulty swallowing	0	1 2 3
8	History of anemia, unresponsive to iron	N	Y (10)
9	Vegetarian (no eggs or dairy)	N	Y (5)
10	Spoon shaped nails	N	Y (3)
11	Unintentional weight loss	N	Y (3)
12	Partial loss of taste or smell	N	Y (3)

SECTION TOTAL _____

SECTION C			
1	Stomach pain, burning, aching 1-4 hours after eating	0	1 2 3
2	Feeling hungry an hour or two after eating	0	1 2 3
3	Strong emotions, thoughts, or smell of food aggravates stomach	0	1 2 3
4	Heartburn, especially when lying down or bending forward	0	1 2 3
5	Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1 2 3
6	Difficulty or pain when swallowing	0	1 2 3
7	Chest pain, difficulty breathing, lung infections	0	1 2 3
8	Temporary relief from antacids, carbonated beverages, cream, milk, food	0	1 2 3
9	Constipation, difficult bowel movements	0	1 2 3
10	Black, tarry stool	0	1 2 3

SECTION TOTAL _____

SECTION B			
1	Indigestion, fullness lasts 2-4 hours after eating	0	1 2 3
2	Pain, tenderness, or soreness on left side under rib cage	0	1 2 3
3	Bloated	0	1 2 3
4	Excessive passage of gas	0	1 2 3
5	Abdominal cramps, aches	0	1 2 3
6	Nausea and/or vomiting	0	1 2 3
7	Specific foods/beverages aggravate indigestion	0	1 2 3
8	Roughage and fiber causes constipation	0	1 2 3
9	Three or more large bowel movements daily	0	1 2 3
10	Alternating constipation and diarrhea	0	1 2 3
11	Undigested food in stool	0	1 2 3
12	Mucus in stool	0	1 2 3
13	Dry, flaky skin; dry brittle hair	N	Y (3)
14	Difficulty gaining weight	N	Y (3)

SECTION TOTAL _____

SECTION D			
1	Lower abdominal pain, cramping, and/or spasms	0	1 2 3
2	Lower abdominal pain relief by passing stool or gas	0	1 2 3
3	Raw fruits, vegetables, or stress aggravate bowel pain	0	1 2 3
4	Diarrhea (loose watery stool)	0	1 2 3
5	More than three bowel movements daily	0	1 2 3
6	Excessive gas and bloating	0	1 2 3
7	Painful, difficult, straining during bowel movements	0	1 2 3
8	Hard, dry, or small stool	0	1 2 3
9	Extremely narrow stool, thin stool	0	1 2 3
10	Alternating diarrhea/constipation	0	1 2 3
11	Mucus or pus in stool	0	1 2 3
12	Feeling that bowels do not empty completely	0	1 2 3
13	Bright red blood following bowel movement	0	1 2 3
14	Anal itching	0	1 2 3

SECTION TOTAL _____

Part II

SECTION A			
1	Moderate to severe pain under right side of rib cage	0	1 2 3
2	Abdominal pain worsens with deep breathing	0	1 2 3
3	Bitter fluid repeats after eating	0	1 2 3
4	Bloated, full feeling	0	1 2 3
5	Belching, heartburn, gas	0	1 2 3
6	Fatty foods cause indigestion	0	1 2 3
7	Nausea or vomiting	0	1 2 3
8	Chronic fatigue	0	1 2 3
9	Unexplained itchy skin worse at night	0	1 2 3
10	Stool color alternates from clay colored to normal brown	0	1 2 3

11	General feeling of poor health	0	1 2 3
12	Fatigue, weakness, exhaustion	0	1 2 3
13	Unable to concentrate, irritable, confused	0	1 2 3
14	Swollen feet and/or legs	0	1 2 3
15	Easy bruising	0	1 2 3
16	Feeling of extreme dryness	0	1 2 3
17	Reddened skin, especially palms	0	1 2 3
18	Dark urine, diminished flow	0	1 2 3
19	Dry, flaky skin or hair	N	Y (3)
20	Yellowish cast to skin, eyes	N	Y (3)

SECTION TOTAL _____

Instructions for Part II (Section B): Rate each of the following symptoms based upon your health profile for the past 30 days or for the past 48 hours if this is a retest.

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

Part II Section B

DIGESTIVE TRACT	SECTION TOTAL			
Nausea or vomiting	0	1	2	3 4
Diarrhea	0	1	2	3 4
Constipation	0	1	2	3 4
Intestinal/stomach pain	0	1	2	3 4
Bloated feeling	0	1	2	3 4
Belching, passing gas	0	1	2	3 4
Heartburn	0	1	2	3 4

EARS	SECTION TOTAL			
Itchy ears	0	1	2	3 4
Earaches, ear infections	0	1	2	3 4
Drainage from ear	0	1	2	3 4
ringing in ears, hearing loss	0	1	2	3 4

EMOTIONS	SECTION TOTAL			
Mood swings	0	1	2	3 4
Anxiety, fear, or nervousness	0	1	2	3 4
Anger, irritability, or aggressiveness	0	1	2	3 4
Depression	0	1	2	3 4

ENERGY/ACTIVITY	SECTION TOTAL			
Fatigue, sluggishness	0	1	2	3 4
Apathy, lethargy	0	1	2	3 4
Hyperactivity	0	1	2	3 4
Restlessness	0	1	2	3 4

EYES	SECTION TOTAL			
Watery or itchy eyes	0	1	2	3 4
Swollen, reddened, or sticky eyelids	0	1	2	3 4
Bags or dark circles under eyes	0	1	2	3 4
Blurred or tunnel vision (not near/far sighted)	0	1	2	3 4

HEAD	SECTION TOTAL			
Headaches	0	1	2	3 4
Faintness	0	1	2	3 4
Dizziness	0	1	2	3 4
Insomnia	0	1	2	3 4

HEART	SECTION TOTAL			
Irregular or skipped heartbeat	0	1	2	3 4
Rapid or pounding heartbeat	0	1	2	3 4
Chest pain	0	1	2	3 4

JOINTS/MUSCLES	SECTION TOTAL			
Pain or aches in joints	0	1	2	3 4
Arthritis	0	1	2	3 4
Stiffness or limitation of movement	0	1	2	3 4
Feeling of weakness or tiredness	0	1	2	3 4
Pain or aches in muscles	0	1	2	3 4

MIND	SECTION TOTAL			
Poor memory	0	1	2	3 4
Confusion, poor comprehension	0	1	2	3 4
Poor concentration	0	1	2	3 4
Poor physical coordination	0	1	2	3 4
Difficulty in making decisions	0	1	2	3 4
Stuttering or stammering	0	1	2	3 4
Slurred speech	0	1	2	3 4
Learning disabilities	0	1	2	3 4

LUNGS	SECTION TOTAL			
Chest congestion	0	1	2	3 4
Asthma, bronchitis	0	1	2	3 4
Shortness of breath	0	1	2	3 4
Difficulty breathing	0	1	2	3 4

MOUTH/THROAT	SECTION TOTAL			
Gagging, frequent clearing of throat	0	1	2	3 4
Sore throat, hoarseness, loss of voice	0	1	2	3 4
Swollen, discolored tongue, gums, lips	0	1	2	3 4
Chronic coughing	0	1	2	3 4
Canker sores	0	1	2	3 4

NOSE	SECTION TOTAL			
Excessive mucus formation	0	1	2	3 4
Stuffy nose	0	1	2	3 4
Sinus problems	0	1	2	3 4
Hay fever	0	1	2	3 4
Sneezing attacks	0	1	2	3 4

SKIN	SECTION TOTAL			
Acne	0	1	2	3 4
Hives, rashes, dry skin	0	1	2	3 4
Hair loss	0	1	2	3 4
Flushing, hot flashes	0	1	2	3 4
Excessive sweating	0	1	2	3 4

WEIGHT	SECTION TOTAL			
Binge eating or drinking	0	1	2	3 4
Craving certain foods	0	1	2	3 4
Excessive weight	0	1	2	3 4
Compulsive eating	0	1	2	3 4
Water retention	0	1	2	3 4
Underweight	0	1	2	3 4

OTHER	SECTION TOTAL			
Frequent illness	0	1	2	3 4
Frequent or urgent urination	0	1	2	3 4
Genital itch or discharge	0	1	2	3 4

GRAND TOTAL THIS PAGE _____

Office Use:	Mild	Moderate	Severe
Part I Gastrointestinal			
A Hypoacidity.....	1	2 3 4	5 6 7 8 9 10 12 14 15
B Small Intestine Exocrine Pancreas	1	2 3 4	5 - 6 8 10 12 14 15
C Gastric Dysfunction.....	1	2 3 4	5 - 6 - 7 - 8 - 9 10 12 14 15
D Colon	1	2 3 4	5 6 7 8 9 10 12 14 15
Part II Liver/Detoxification			
A Liver/Gallbladder	1	2 3 - 4	7 10 - 12 13 15 17 18
B Detoxification	10	20 30 35	40 44 48 50 62 72 82 92 100