Symptom Checklist

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If you have one or more of these symptoms, there's a 95% probability you'll benefit from a food sensitivity test.

Please place a checkmark at each of your symptoms and return the completed checklist to your physician. Be sure to include symptoms that you've 'learned to live with'.

Digestive Tract
❏ Belching
❏ Bloated feeling
❏ Constipation
❏ Diarrhea
❏ Nausea
❏ Passing gas
❏ Stomach pains
❏ Vomiting

Ears
❏ Drainage from ear
❏ Ear aches
❏ Ear infections
❏ Hearing loss
❏ Itchy ears
❏ Ringing in ears

Emotions
❏ Aggressiveness
❏ Anxiety/fear
❏ Depression
❏ Irritability/anger
❏ Mood swings
❏ Nervousness

Energy & Activity
❏ Apathy
❏ Fatigue
❏ Hyperactivity
❏ Lethargy
❏ Restlessness
❏ Sluggishness

Eyes
❏ Blurred vision
❏ Dark circles
❏ Itchy eyes
❏ Sticky eyelids
❏ Swollen eyelids
❏ Watery eyes

Head
❏ Dizziness
❏ Faintness
❏ Headaches
❏ Insomnia
❏ Lightheadedness

Joint & Muscles
❏ Aches in muscles
❏ Arthritis
❏ Feeling of weakness
❏ Limited movement
❏ Pain in joints
❏ Stiffness

Lungs
❏ Asthma/bronchitis
❏ Chest congestion
❏ Difficulty breathing
❏ Shortness of breath
❏ Wheezing

Mind
❏ Confusion
❏ Learning disabilities
❏ Poor concentration
❏ Poor memory
❏ Stuttering/stammering

Mouth & Throat
❏ Canker sores
❏ Chronic coughing
❏ Gagging
❏ Often clear throat
❏ Sore throat
❏ Swollen tongue/lips/gums

Nose
❏ Excessive mucous
❏ Hay fever
❏ Sinus problems
❏ Sneezing attacks
❏ Stuffy nose

Skin
❏ Acne
❏ Dermatitis
❏ Eczema
❏ Excessive sweating
❏ Flushing/hot flashes
❏ Hair loss
❏ Hives/rashes
❏ Itching

Weight
❏ Binge eating
❏ Compulsive eating
❏ Cravings
❏ Excessive weight
❏ Underweight
❏ Water retention

Other
❏ Anaphylactic reactions
❏ Chest pains
❏ Frequent illness
❏ Genital itch
❏ Irregular heartbeat
❏ Rapid heartbeat
❏ Urgent urination

Patient's Name:______________________ Phone #:______________________
Address:____
Weight:______________ Height:______________

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Symptom Checklist *(continued)*

During the last 30 days, have the symptoms you noted on the previous page…

1. **Prevented you from getting a good night's sleep?** ❑ Yes ❑ No

   If yes, which symptoms? ______________________ How many nights? ________

2. **Affected your performance at your place of employment?** ❑ Yes ❑ No

   If yes, which symptoms? ______________________ How many days? ________

3. **Caused you to call in sick to your place of employment?** ❑ Yes ❑ No

   If yes, which symptoms? ______________________ How many days? ________

4. **Caused you to leave your place of employment early?** ❑ Yes ❑ No

   If yes, which symptoms? ______________________ How many days? ________

Do you or anyone in your family have a history of allergies? ❑ Yes ❑ No

Have you or has anyone in your family ever been to an allergist or been tested for allergies?

❑ Yes ❑ No

Do you have allergic reactions within 15 minutes or sooner after exposure to particular topical, ingested or inhaled substances such as:

- ❑ Animal danders
- ❑ Cosmetics
- ❑ Dust, pollen or mold
- ❑ Foods
- ❑ Insect stings
- ❑ Iodine
- ❑ Latex
- ❑ Laundry detergent
- ❑ Medicines
- ❑ Penicillin
- ❑ Plants or trees
- ❑ Shampoos or soaps
- ❑ Skin creams
- ❑ Sulfur

If so, can you identify the particular offending substance?

____

Do you have severe, dramatic allergic reactions (anaphylaxis) with skin reactions, swelling, respiratory distress, and/or low blood pressure?

____

If so, what causes it? (eg., bee stings, penicillin, etc.)

____