Digestive Wellness

Patient Assessment Questionnaire

Name ______________________________

Today's Date ______________________________

Date of Birth ______________________________

Sex ______________________________

INSTRUCTIONS: Please read each section below carefully and, after each symptom, circle the number in the column that best describes how that statement applies to you. Choose the number based on how often you feel the symptom. However, if you feel a symptom only sometimes, but the intensity is severe, circle 3 in the appropriate column of the questionnaire. After each section, write down any additional information for your healthcare practitioner in the area marked "Additional Comments." After completing the questionnaire, return it to your healthcare practitioner.

Almost never: (NA) (0 points)

Sometimes: (Mild) (1 point)

Often: (Moderate) (2 points)

Most of the time: (Severe) (3 points)

Your Healthcare Practictioner will calculate and evaluate your score.

Section A:

Circle the number in the column that best describes your symptoms/how you feel.

	Almost never (None)	Sometimes (Mild)	Often (Moderate)	Most of the time (Severe)
Stomach easily upset after eating	**0**	**1**	**2**	**3**
Bloating in stomach, upper abdomen	**0**	**1**	**2**	**3**
Burning or belching	**0**	**1**	**2**	**3**
Feeling of undigested food in stomach	**0**	**1**	**2**	**3**
Uncomfortable fullness in stomach	**0**	**1**	**2**	**3**
Known or suspected food allergies, sensitivities, or intolerances (specify below)	**0**	**1**	**2**	**3**
Fullness after small amounts of food	**0**	**1**	**2**	**3**
Sum of each column	**0**			
Total Score (sum of all columns)				

Additional comments related to symptoms: ______________________________

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SECTION B:

Circle the number in the column that best describes your symptoms/how you feel.

	Almost never (None)	Sometimes (Mild)	Often (Moderate)	Most of the time (Severe)
Burning or gnawing stomach pain	**0**	**1**	**2**	**3**
Heartburn or indigestion	**0**	**1**	**2**	**3**
Pain relieved by antacids	**0**	**1**	**2**	**3**
Stomach pain from stress or spicy foods	**0**	**1**	**2**	**3**
Waking at night with stomach pain	**0**	**1**	**2**	**3**
Pain temporarily improved by eating food or drinking milk	**0**	**1**	**2**	**3**
History of ulcer, gastritis, or antacid use	**0**	**1**	**2**	**3**
Nausea or vomiting after eating	**0**	**1**	**2**	**3**
Use of aspirin or anti-inflammatory drugs	**0**	**1**	**2**	**3**
Sum of each column	**0**			
Total score (sum of all columns)				

Additional comments related to symptoms: ______________________________

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Section C:

Circle the number in the column that best describes your symptoms/how you feel.

	Almost never (None)	Sometimes (Mild)	Often (Moderate)	Most of the time (Severe)
Bloating 1-3 hours or more after eating	**0**	**1**	**2**	**3**
Bloating in lower abdomen	**0**	**1**	**2**	**3**
Foul-smelling stools or gas	**0**	**1**	**2**	**3**
Shiny or loose, floating stools	**0**	**1**	**2**	**3**
Abdominal cramping or pain	**0**	**1**	**2**	**3**
Diarrhea or poorly formed stools	**0**	**1**	**2**	**3**
Known or suspected food allergies, sensitivities, or intolerances (specify below)	**0**	**1**	**2**	**3**
Difficulty gaining weight	**0**	**1**	**2**	**3**
Undigested food or mucus in stools	**0**	**1**	**2**	**3**
Sum of each column	**0**			
Total Score (sum of all columns)				

Additional comments related to symptoms: ______________________________

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SECTION D:

Circle the number in the column that best describes your symptoms/how you feel.

	Almost never (None)	Sometimes (Mild)	Often (Moderate)	Most of the time (Severe)
Constipation and/or diarrhea	**0**	**1**	**2**	**3**
Abdominal pain or bloating	**0**	**1**	**2**	**3**
Mucus or blood in stool	**0**	**1**	**2**	**3**
Joint pain, swelling, or arthritis	**0**	**1**	**2**	**3**
Chronic or frequent fatigue or tiredness	**0**	**1**	**2**	**3**
Known or suspected food allergies, sensitivities, or intolerances (specify below)	**0**	**1**	**2**	**3**
Sinus or nasal congestion	**0**	**1**	**2**	**3**
Chronic or frequent inflammations	**0**	**1**	**2**	**3**
Eczema, skin rashes, or hives	**0**	**1**	**2**	**3**
Asthma, hayfever, or airborne allergies	**0**	**1**	**2**	**3**
Confusion, poor memory, or mood swings	**0**	**1**	**2**	**3**
Use of aspirin or anti-inflamatory drugs	**0**	**1**	**2**	**3**
History of antibiotic and/or corticosteroid use	**0**	**1**	**2**	**3**
Alcohol use	**0**	**1**	**2**	**3**
Sum of each column	**0**			
Total Score (sum of all columns)				

Additional comments related to symptoms: ______________________________

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SECTION E:

Circle the number in the column that best describes your symptoms/how you feel.

	Almost never (None)	Sometimes (Mild)	Often (Moderate)	Most of the time (Severe)
Dislike or can't tolerate fatty foods	**0**	**1**	**2**	**3**
Headaches after eating	**0**	**1**	**2**	**3**
Light-colored stools	**0**	**1**	**2**	**3**
Constipation	**0**	1	**2**	**3**
Hard stool	**0**	**1**	**2**	**3**
Oily skin	**0**	**1**	**2**	**3**
Acne	**0**	**1**	**2**	**3**
Pain or tenderness under right side of ribs	**0**	**1**	**2**	**3**
Elevated cholesterol or triglycerides, if known	**0**	**1**	**2**	**3**
Hemorrhoids	**0**	**1**	**2**	**3**
Bleeding during or after bowel movements	**0**	**1**	**2**	**3**
Sum of each column	**0**			
Total Score (sum of all columns)				

Additional comments related to symptoms: ______________________________

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For Office Use Only:

Summary of Scores:

	Score
Section A	
Section B	
Section C	
Section D	
Section E	