DIGESTIVE RESTORATION

Patient Assesment 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 professional in the area marked "Additional Comments." After completing the questionnaire, return it to your healthcare professional.

Almost never: (NA) (0 points)

Sometimes: (Mild) (1 point)

Often: (Moderate) (2 points)

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

Your Healthcare Professional 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: _____

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**
Gallbladder removed (0=No, 3=Yes)	**0**	**NA**	**NA**	**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)
Occasional constipation and/or loose stools	**0**	**1**	**2**	**3**
Abdominal pain or cramping	**0**	**1**	**2**	**3**
Blood or mucus in stool	**0**	**1**	**2**	**3**
Itchy or rash around rectum	**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 inflammation	**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-inflammatory 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	