**The Food Intolerance Questionnaire**

Do you suffer on a regular basis (i.e.: 3 or more times per week) from any of the following?

**Section One-Digestive Symptoms**

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| --- | --- | --- |
| **Symptom** | **Yes-have Symptoms** | **No-have no Symptoms** |
| Abdominal bloating/distention | Yes | No |
| Abdominal cramps | Yes | No |
| Stomach pain | Yes | No |
| Burping after eating certain foods | Yes | No |
| Difficulty losing weight | Yes | No |
| Difficulty gaining weight | Yes | No |
| Bed wetting | Yes | No |
| Excess flatulence | Yes | No |
| Gallbladder issues-difficulty digesting fats | Yes | No |
| Reflux (GERD) | Yes | No |
| Gritty feeling in eyes | Yes | No |
| indigestion | Yes | No |
| Inexplicable weight gain/loss | Yes | No |
| Irregular bowels-diarrhea, constipation | Yes | No |
| Irritable bowel syndrome | Yes | No |
| Inflammatory bowel disease | Yes | No |
| Itchy bottom | Yes | No |
| Itchy red ears | Yes | No |
| Metallic taste in mouth | Yes | No |
| Mouth ulcers | Yes | No |
| nausea | Yes | No |
| Persistent need to clear throat | Yes | No |
| Chronic sore throat | Yes | No |
| Post nasal drip/runny nose | Yes | No |
| Chronic sinus congestion | Yes | No |
| Sneezing-frequent | Yes | No |
| Water retention | Yes | No |
| Ear infections | Yes | No |

**Section 2-mental, emotional, nervous system symptoms**

|  |  |  |
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| **Symptom** | **Yes-Have Symptoms** | **No-Have no Symptoms** |
| Addictions | Yes | No |
| Aggressive Outbursts | Yes | No |
| ADD/ADHD | Yes | No |
| Anxiety | Yes | No |
| Behavioral issues | Yes | No |
| Momentarily difficulty finding the right words | Yes | No |
| Blurred vision | Yes | No |
| Brain fog | Yes | No |
| Clumsiness | Yes | No |
| Confusion | Yes | No |
| Constant hunger | Yes | No |
| Dark circles under eyes | Yes | No |
| Depression | Yes | No |
| Dilated blood vessels in cheeks or nose | Yes | No |
| Dizziness | Yes | No |
| Dyslexia | Yes | No |
| Fidgeting | Yes | No |
| Foggy head | Yes | No |
| Food cravings | Yes | No |
| Headaches | Yes | No |
| Hyperactive | Yes | No |
| Inability to think clearly | Yes | No |
| insomnia | Yes | No |
| Irritability | Yes | No |
| Lack of motivation | Yes | No |
| Migraines | Yes | No |
| Mood swing | Yes | No |
| Palpitations | Yes | No |
| Panic attacks | Yes | No |
| Phobias | Yes | No |
| Poor concentration | Yes | No |
| Racing pulse | Yes | No |
| Restless leg syndrome | Yes | No |
| Slurred speech | Yes | No |
| Spacey | Yes | No |

**Section 3-Overt Physical Signs and Symptoms**

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| --- | --- | --- |
| **Symptoms** | **Yes-have Symptoms** | **No-have no Symptoms** |
| Abnormal physical weakness or tiredness | Yes | No |
| Aching muscles and joints for no good reason | Yes | No |
| Arthritis | Yes | No |
| Asthma | Yes | No |
| Chronic infections | Yes | No |
| Eczema | Yes | No |
| Fibromyalgia | Yes | No |
| Hives | Yes | No |
| Itching | Yes | No |
| Painful joints in which pain moves from one joint to another | Yes | No |
| Painful joint that is not associated with excessive use | Yes | No |
| Psoriasis | Yes | No |
| Rheumatoid arthritis | Yes | No |
| Rough dry skin | Yes | No |
| Acne | Yes | No |
| Wheezing | Yes | No |
|  | Yes | No |