GI RESTORATION

Patient Assessment Questionnaire

Name_____Date of Birth ___/___/___Today's Date___/___/___

INSTRUCTIONS: Please read each section below carefully and, after each symptom, mark the applicable box in the column that best describes how that statement applies to you. Mark the box based on how often or how severe you feel the symptom. Clarify any additional related information in the area marked "Additional Comments." Some items appear in multiple sections. If you are unsure, leave that item blank and discuss with your healthcare professional. After completing the questionnaire, return it to your healthcare professional.

Almost never or Not Applicable: 0 points
Sometimes or Mild: 1 point
Often or Moderate: 2 points
Most of the time or Severe: 3 points

Your Healthcare Professional will calculate and evaluate your score.

SECTION A: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
Stomach easily upset after eating	☐	☐	☐	☐
Bloating in stomach, upper abdomen	☐	☐	☐	☐
Burning or belching	☐	☐	☐	☐
Feeling of undigested food in stomach	☐	☐	☐	☐
Uncomfortable fullness in stomach	☐	☐	☐	☐
Known or suspected food allergies, sensitivities, or intolerances (specify below)	☐	☐	☐	☐
Fullness after small amounts of food	☐	☐	☐	☐
FOR OFFICE USE ONLY Sum of each column	_____	_____	_____	
Total Score (sum of all columns)				

Additional comments related to symptoms:_____

SECTION A1: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
Bloating 1-3 hours or more after eating	☐	☐	☐	☐
Bloating in lower abdomen	☐	☐	☐	☐
Foul-smelling stools or gas	☐	☐	☐	☐
Shiny or loose, floating stools	☐	☐	☐	☐
Abdominal cramping or pain	☐	☐	☐	☐
Diarrhea or poorly formed stools	☐	☐	☐	☐
Known or suspected food allergies, sensitivities, or intolerances (specify below)	☐	☐	☐	☐
Difficulty gaining weight	☐	☐	☐	☐
Undigested food or mucus in stools	☐	☐	☐	☐
Gallbladder removed	☐	☐	☐	☐
FOR OFFICE USE ONLY Sum of each column				
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

SECTION B: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
Burning or gnawing stomach pain	☐	☐	☐	☐
Heartburn or indigestion	☐	☐	☐	☐
Pain relieved by antacids	☐	☐	☐	☐
Stomach pain from stress or spicy foods	☐	☐	☐	☐
Waking at night with stomach pain	☐	☐	☐	☐
Pain temporarily improved by eating food or drinking milk	☐	☐	☐	☐
History of ulcer, gastritis, or antacid use	☐	☐	☐	☐
Nausea or vomiting after eating	☐	☐	☐	☐
Use of aspirin or anti-inflammatory drugs	☐	☐	☐	☐
FOR OFFICE USE ONLY Sum of each column				
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

SECTION C: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
Avoiding certain foods improves condition	☐	☐	☐	☐
Skin rashes	☐	☐	☐	☐
Cravings for sugar or carbohydrates	☐	☐	☐	☐
Joint pain that comes and goes	☐	☐	☐	☐
Mood is affected by foods	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Poor memory or feeling spacey	☐	☐	☐	☐
Become sick easily	☐	☐	☐	☐
Celiac	☐	☐	☐	☐
FOR OFFICE USE ONLY Sum of each column		_____	_____	_____
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

SECTION D: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
Diarrhea and/or constipation	☐	☐	☐	☐
Abdominal pain	☐	☐	☐	☐
Belching, flatulence (gas), distension	☐	☐	☐	☐
Poor appetite	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Weight loss	☐	☐	☐	☐
FOR OFFICE USE ONLY Sum of each column		_____	_____	_____
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

SECTION D1: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
History of antibiotic use				
Fatigue				
Poor memory or feeling spacey				
Insomnia or excessively sleepy				
Mood swings				
Muscle and/or joint pain				
Alcohol intolerance				
Itchy skin				
FOR OFFICE USE ONLY Sum of each column				
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

SECTION E: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
GI symptoms are difficult to describe				
Feel toxic or sluggish in many ways				
Admit to poor diet				
Sensitive to many foods				
Require “low dose” of most medications or supplements				
React to cosmetics, perfumes, and certain smells				
Sensitive to environmental influences				
Headaches after eating				
Acne				
Pain or tenderness under right side of ribs				
Elevated cholesterol or triglycerides, if known				
Hemorrhoids				
Bleeding during or after bowel movements				
FOR OFFICE USE ONLY Sum of each column				
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

SECTION F: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
Stress affects GI symptoms	☐	☐	☐	☐
Antibiotic use	☐	☐	☐	☐
Constipation or diarrhea	☐	☐	☐	☐
A sense of generally poor digestion	☐	☐	☐	☐
Eat processed foods	☐	☐	☐	☐
Recurrent infections	☐	☐	☐	☐
Hospitalizations	☐	☐	☐	☐
FOR OFFICE USE ONLY Sum of each column	____	____	____	____
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

SECTION F1: Select the descriptor in the column that best describes your symptoms/how you feel.	ALMOST NEVER/ N/A	SOMETIMES/ MILD	OFTEN/ MODERATE	MOST OF THE TIME/ SEVERE
Carbohydrate intolerance	☐	☐	☐	☐
Fiber intolerance	☐	☐	☐	☐
Bloating after meals	☐	☐	☐	☐
Low iron, if known	☐	☐	☐	☐
Low vitamin D, if known	☐	☐	☐	☐
Low B12, if known	☐	☐	☐	☐
Fat malabsorption	☐	☐	☐	☐
Sensitive to many foods	☐	☐	☐	☐
Systemic inflammation	☐	☐	☐	☐
Autoimmune dysfunction	☐	☐	☐	☐
Condition of chronic infection	☐	☐	☐	☐
FOR OFFICE USE ONLY Sum of each column	____	____	____	____
Total Score (sum of all columns)				

Additional comments related to symptoms: _____

FOR OFFICE USE ONLY

SCORES:

Section A	
Section A1	
Section B	
Section C	
Section D	
Section D1	
Section E	
Section F	
Section F1	

Summary of Scores