

# Food and Chemical Sensitivity Survey



Date: \_\_\_/\_\_\_/\_\_\_

Patient Name \_\_\_\_\_

Gender: M/F

Height: Feet \_\_\_ Inches \_\_\_

Weight: \_\_\_ lbs.

Please list all medications you are currently taking: \_\_\_\_\_

**Please complete the following food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 60 days. This survey should be taken again after the completion of the Alcat Test, prior to reintroduction of "reactive" foods. Typically 3-6 months after initial testing. This comparison will help to assess the success of the eating modification program.**

### Symptom Scoring System:

- = No Symptoms (Zero Points)
- = Experience Mild Symptoms (One Point)
- = Experience Moderate Symptoms (Two Points)
- = Severe Symptoms (Three Points)

### Digestive Symptoms

- Stomach Pains or Cramping
- Constipation
- Diarrhea
- Reflux or Heartburn
- Bloating
- Gas
- Nausea or Vomiting

### Weight

- Inability to Lose Weight
- Food Cravings
- Binge Eating
- Water Retention

### Sinus/Respiratory

- Stuffy or Runny Nose
- Asthma
- Chest Congestion
- Chronic Cough
- Wheezing
- Frequent Sneezing

### Head/Ears

- Migraines
- Headaches
- Earaches
- Ear Infection
- Ringing in Ears

### Eyes/Throat

- Itchy Eyes
- Watery Eyes
- Sore Throat
- Persistent Canker Sores

### Emotional/Mental

- Depression
- Anxiety
- Mood Swings
- Irritability
- Poor Concentration

### Energy

- Fatigue
- Hyperactivity
- Lethargy
- Restlessness
- Insomnia

### Skin Disorders

- Eczema
- Dermatitis
- Excessive Sweating
- Rashes
- Hives

### Other Symptoms:

- Joint Pain
- Arthritis
- Irregular Heartbeat
- Chest Pains
- Muscle Aches

Please list any symptoms not mentioned above:

\_\_\_\_\_

\_\_\_\_\_

**Total Score: \_\_\_\_\_**