

Name: \_\_\_\_\_ Date: \_\_\_\_\_

For questions in each section of this questionnaire, choose the most appropriate response. Note that each answer is assigned a point value to help determine your symptoms score for each section. Your responses will help your healthcare provider personalize a nutritional program for you.

### Part 1: Occasional Stomach-Related Symptoms

With or without meals, how often do you experience stomach spasms or cramps?

- Never (0 pts.)       Seldom (1 pt.)       Frequently (8 pts.)

With or without meals, do strong emotions ever cause stomach pain/ache or other digestive-related discomfort?

- Never (0 pts.)       Seldom (1 pt.)       Frequently (4 pts.)

With or without meals, do you ever feel a burning sensation in your stomach?

- Never (0 pts.)       Seldom (1 pt.)       Frequently (8 pts.)

Do you notice that certain foods (e.g., spicy or acidic foods, coffee, citrus) cause burning or aching anywhere in your stomach or upper digestive tract?

- Never (0 pts.)       Seldom (1 pt.)       Frequently (8 pts.)

Do you ever experience nausea with meals?

- Never (0 pts.)       Seldom (1 pt.)       Frequently (4 pts.)

**Total score:** \_\_\_\_\_

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### Part 2: Stomach-Related Symptoms

During or shortly after meals, indicate how often you experience the following symptoms:

Bad taste in the mouth (heartburn)

- Never (0 pts.)       Seldom (1 pt.)       Frequently (4 pts.)

Burping and belching

- Never (0 pts.)       Seldom (1 pt.)       Frequently (4 pts.)

Bloating or fullness in the upper digestive tract (e.g., stomach, esophagus, diaphragm)

- Never (0 pts.)       Seldom (1 pt.)       Frequently (4 pts.)

Lack of appetite

- Never (0 pts.)       Seldom (1 pt.)       Frequently (4 pts.)

Food “repeats”

- Never (0 pts.)       Seldom (1 pt.)       Frequently (4 pts.)

**Total score:** \_\_\_\_\_

## Part 3: Other Gastrointestinal Symptoms

Have you experienced chronic intestinal or lower bowel discomfort (seemingly unrelated to meals) for more than 6 months?

- No (0 pts.)                       Yes (16 pts.)

Do you have autoimmune issues?

- No (0 pts.)                       Yes (16 pts.)

For 1 to 4 hours after meals, indicate how often you experience the following symptoms:

Lower abdominal bloating, cramping, and/or gas

- Never (0 pts.)                       Seldom (1 pt.)                       Frequently (8 pts.)

Lack of appetite

- Never (0 pts.)                       Seldom (1 pt.)                       Frequently (4 pts.)

Strong stool odor

- Never (0 pts.)                       Seldom (1 pt.)                       Frequently (8 pts.)

Gas and bloating with fatty foods

- Never (0 pts.)                       Seldom (1 pt.)                       Frequently (8 pts.)

Undigested food particles in stool

- Never (0 pts.)                       Seldom (1 pt.)                       Frequently (8 pts.)

Fatty stool or mucus in stool

- Never (0 pts.)                       Seldom (1 pt.)                       Frequently (8 pts.)

Loose stools or diarrhea

- Never (0 pts.)                       Seldom (1 pt.)                       Frequently (4 pts.)

**Total score:** \_\_\_\_\_

## For Practitioner Use Only

Score	Recommendations
Part 1: _____	_____
Part 2: _____	_____
Part 3: _____	_____