Digestion Assessment

Name					
Age		**Height**		**Weight**	

Based upon your health profile for **the past 30 days** , please select the appropriate number, from '0 - 3' on all questions (0 as least/never/no and 3 as most/always/yes). Each choice has been given a score. Circle the number/score you feel best applies, then add the scores in each column to create your subtotals. The sum of the subtotals will create your grand score.

Point Scale:	For all **yes/no** questions, **0 = no and 3 = yes**
0 = **Never** or almost never have the experience/effect. **1** = **Mild** experiences/effects **2** = **Moderate** experiences/effects **3** = **Severe/chronic** experiences/effects	

Upper Gastrointestinal - low stomach acid/digestive enzymes	**0**	**1**	**2**	**3**
Do you experience belching or gas within one hour after eating?	0	1	2	3
Do you experience heartburn or acid reflux?	0	1	2	3
Do you experience bloating within one hour after eating?	0	1	2	3
Do you have bad breath?	0	1	2	3
Have you experienced a loss of taste for meat?	0	1	2	3
Does your sweat have a strong odor?	0	1	2	3
Do you experience stomach upset by taking vitamins?	0	1	2	3
Do you feel a sense of excess fullness after meals?	0	1	2	3
Do you feel better if you don't eat?	0	1	2	3
Do you feel sleepy after meals?	0	1	2	3
Do your fingernails chip, peel or break easily?	0	1	2	3
Do you have anemia (low red blood cells count) that is unresponsive to iron?	0	1	2	3
Do you experience stomach pains or cramps?	0	1	2	3
Do you have chronic diarrhea?	0	1	2	3
Do you experience diarrhea shortly after meals?	0	1	2	3

Is there ever undigested food in your stool?	0	1	2	3
Subtotal for Upper Gastrointestinal Symptoms – low stomach acid (sum of cores)				
Subtotal /48				

Upper Gastrointestinal - excess stomach acid	**0**	**1**	**2**	**3**
Do you ever have black or tarry colored stools?	0	1	2	3
Do you experience stomach pain, burning or aching 1-4 hours after eating?	0	1	2	3
Do you use antacids?	0	1	2	3
Do you ever feel hungry an hour to two hours after eating?	0	1	2	3
Do you experience heartburn from spicy foods, chocolate, citrus, peppers, alcohol, and/or caffeine?	0	1	2	3
Do you receive temporary heartburn relief from antacids, food, milk or carbonated beverages?	0	1	2	3
Do your digestive problems subside with rest and relaxation?	0	1	2	3
Subtotal for Upper Gastrointestinal Symptoms – excess stomach acid (sum of scores)				
Subtotal /21				

Liver and Gallbladder	**0**	**1**	**2**	**3**
Do you experience pain between your shoulder blades?	0	1	2	3
Do you experience stomach upset by eating greasy foods?	0	1	2	3
Do you ever have greasy or shiny stools?	0	1	2	3
Do you experience nausea or motion sickness (sea, car, or airplane)	0	1	2	3
Do you have a history of morning sickness? 0 = never, 1 = years ago, 2 = within last year,3 = within past 3 months	0	1	2	3
Do you ever have light or clay colored stools?	0	1	2	3

Heal Your Hormones

Do you have dry skin, itchy feet, or skin peels on your feet?	0	1	2	3
Do you ever feel headaches "over your eyes"?	0	1	2	3
Have you ever had a gallbladder attack(s)? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months	0	1	2	3
Has your gallbladder been removed?	0			3
Do you ever experience a bitter taste in your mouth, especially after meals?	0	1	2	3
Would you become sick or easily intoxicated if you were to drink alcohol?	0	1	2	3
Would you be easily hung over if you were to drink alcohol?	0	1	2	3
Are you a recovering alcoholic?	0			3
How many alcoholic drinks do you consume per week? 0 = <3, 1 = <7, 2 = <14, 3 = >=14	0	1	2	3
Do you have a history of drug or alcohol abuse? 0 = never, 1 = years ago, 2 = within last year,3 = within past 3 months	0	1	2	3
Do you have a history of hepatitis? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months	0	1	2	3
Are you sensitive to chemicals?	0	1	2	3
Do you have a history of long term use of prescription/recreational drugs? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months	0	1	2	3
Are you sensitive to tobacco smoke?	0	1	2	3
Are you sensitive when exposed to diesel fumes?	0	1	2	3
Do you ever feel pain under the right side of your rib cage?	0	1	2	3
Do you have hemorrhoids or varicose veins?	0	1	2	3
Do you consume NutraSweet (aspartame)?	0	1	2	3
Are you sensitive to NutraSweet (aspartame)?	0	1	2	3
Do you have chronic fatigue or Fibromyalgia?	0	1	2	3
Do you have lower bowel gas and/or bloating several hours after eating?	0	1	2	3
Is there a yellowish cast to your eyes?	0	1	2	3

Do you have reddened skin, especially your palms?	0	1	2	3
Subtotal for Liver and Gallbladder Symptoms (sum of scores)				
Subtotal /90				

Digestion Assessment Scorecard

Small Intestine and Pancreas	**0**	**1**	**2**	**3**
Do you have any known food allergies?	0	1	2	3
Do you experience abdominal bloating 1 to 2 hours after eating?	0	1	2	3
Do specific foods make you tired or bloated?	0	1	2	3
Does your pulse increase after eating?	0	1	2	3
Do you have any airborne allergies?	0	1	2	3
Do you experience hives?	0	1	2	3
Do you experience sinus congestion or "stuffy head"?	0	1	2	3
Do you crave bread or noodles?	0	1	2	3
Do you alternate between constipation and diarrhea?	0	1	2	3
Do you have a history of Crohn's disease? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months	0	1	2	3
Are you sensitive to wheat or grains?	0	1	2	3
Are you sensitive to dairy?	0	1	2	3
Are there foods you could not give up?	0	1	2	3
Do you have issues with asthma, sinus infections, and/or a stuffy nose?	0	1	2	3
Do you have bizarre, vivid dreams and/or nightmares?	0	1	2	3
Do you use over-the-counter pain medications?	0	1	2	3
Do you ever feel spacey or unreal?	0	1	2	3
Does eating roughage and fiber cause constipation?	0	1	2	3
Do you have indigestion and fullness that lasts 2-4 hours after eating?	0	1	2	3

Do you ever feel pain, tenderness, soreness on your left side under your rib cage?	0	1	2	3
Do you experience excessive passage of gas?	0	1	2	3
Do you experience nausea and/or vomiting?	0	1	2	3
Do you notice your stool is undigested, foul smelling, mucous-like, greasy, and/or poorly formed?	0	1	2	3
Do you frequently need to urinate?	0	1	2	3
Do you have intense thirst and appetite?	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3
Subtotal for Small Intestine and Pancreas Symptoms (sum of scores)				
Subtotal /78				

Large Intestine	**0**	**1**	**2**	**3**
Do you ever have issues with your anus being itchy?	0	1	2	3
Is your tongue coated?	0	1	2	3
Do you feel worse in moldy or musty places?	0	1	2	3
Have you taken antibiotics for a total accumulated time of: 0 = never, 1 = <1 month, 2 = <3 months, 3 = >3 months	0	1	2	3
Do you ever have fungus or yeast infections?	0	1	2	3
Do you have ringworm, "jock itch", "athletes foot", and/or nail fungus?	0	1	2	3
Do any yeast related symptoms increase with sugar, starch or alcohol?	0	1	2	3
Are your stools hard or difficult to pass?	0	1	2	3
Do you have a history of parasites? 0 = never, 1 = <1 month, 2 = <3 months, 3 = >3 months	0	1	2	3
Do you have less than one bowel movement per day?	0	1	2	3
Do your stools ever have: corners, edges, flat shapes, ribbon shapes	0	1	2	3
Are your stools not well formed (loose)?	0	1	2	3

Do you have irritable bowel or mucus colitis?	0			3
Do you ever have blood in your stool?	0	1	2	3
Do you ever have mucus in your stool?	0	1	2	3
Do you ever have excessive foul smelling lower bowel gas?	0	1	2	3
Do you have bad breath or strong body odors?	0	1	2	3
Is it painful to press along the outer sides of your thighs (Iliotibial Band)?	0	1	2	3
Do you have cramping in your lower abdominal region?	0	1	2	3
Do you have dark circles under your eyes?	0	1	2	3
Do you ever have the feeling that your bowels do not empty completely?	0	1	2	3
Do you experience lower abdominal pain relief by passing stool or gas?	0	1	2	3
Do you have alternating constipation and diarrhea?	0	1	2	3
Do you ever experience diarrhea?	0	1	2	3
Do you ever experience constipation?	0	1	2	3
Do you have more than 3 bowel movements daily?	0	1	2	3
Do you ever have a need for laxatives?	0	1	2	3
Subtotal for Large Intestine Symptoms (sum of scores)				
Subtotal /81				
Grand Total (sum of the five Subtotals) /327				

Interpretation

0-10% - Overall good balance. Sound nutrition and healthy habits will maintain good balance.

11-20% - In need of a tune up to restore balance before serious illness sets in. Diet and lifestyle improvements should shift to normal.

21-35% - Things are out of balance and need attention.

36-50% - Very compromised and likely to significantly affect your state of health, well-being and energy level.

51-100% - Severely compromised and requires immediate attention.

Ref Institute For Nutritional Endocrinology