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 Point*s)
○○○● = 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: _____

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