

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

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloating in lower abdomen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foul-smelling stools or gas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shiny or loose, floating stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal cramping or pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea or poorly formed stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Known or suspected food allergies, sensitivities, or intolerances (specify below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty gaining weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undigested food or mucus in stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gallbladder removed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heartburn or indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain relieved by antacids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach pain from stress or spicy foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Waking at night with stomach pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain temporarily improved by eating food or drinking milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of ulcer, gastritis, or antacid use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea or vomiting after eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of aspirin or anti-inflammatory drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin rashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cravings for sugar or carbohydrates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joint pain that comes and goes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood is affected by foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor memory or feeling spacey	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Become sick easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Celiac	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Belching, flatulence (gas), distension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor memory or feeling spacey	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insomnia or excessively sleepy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle and/or joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Itchy skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel toxic or sluggish in many ways	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Admit to poor diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitive to many foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Require "low dose" of most medications or supplements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
React to cosmetics, perfumes, and certain smells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitive to environmental influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches after eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain or tenderness under right side of ribs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elevated cholesterol or triglycerides, if known	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemorrhoids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding during or after bowel movements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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

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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

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Sum of each column

Total Score (sum of all columns)

Additional comments related to symptoms: _____

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SCORES:

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

Summary of Scores