## **Digestive Dysfunction Self-Test**

Please score symptoms you are experiencing and return self-test to your wellness clinician. Scoring is as follows: Never = 0 Monthly = 1 Weekly = 2 Daily = 3

Name		Date	
Section 1: Bad breath (halitosis) Loss of taste for high protein Burning ("acid") or nervous Gas shortly after eating Indigestion ½ to 1 hour after Acidic or spicy foods upset s Chronic asthma, airborne and H-Pylori infection and /or in Gluten/Casein Sensitivity Take over-the-counter or pre	stomach r eating, may last up b 3-4 stomach d food allergies testinal parasites		Score
Section 2: Lower bowel gas and / or blo Feet burn "Whites" of the eyes (sclera) Dry skin, itchy feed and / or Brown spots or bronzing of to Bitter metallic taste Blurred vision Headache over eyes Feel nauseous, queasy or gag Color of stools light brown of Greasy or high fat foods caus Pain between shoulder blade Dark circles under eyes "Acid" breath History of gall bladder attack Gallstones	oating several hours after e ) yellow skin peels on feet the skin g easily or yellow se distress		Score
Section 3: Bloating especially after eating Abnormal gas or flatulence Undigested food in the stool Abdominal fullness or pain, Constant diarrhea and/or alter Muscle weakness, headacher Sleepy or brain fog after mea Type II Diabetes, Fibromya Taking probiotics or prebioti	cramps ernating diarrhea with cons , G.I. distress, after high ca als especially a high carbo llgia or Chronic Fatigue	Section . tipation rb meal or starchy veg	
Section 4: Coated tongue or "fuzzy" de Pass large amounts of foul su Irritable bowel or mucous co	melling gas	Section 4	4 Score

- Constipation, diarrhea, or stools alternate from soft to watery
- Bowel movements painful or difficult, and / or laxatives used
- Burning or itching anus

Total Score