Symptom Questionnaire

Name_____ Date_____

Answer the questions below to the best of your ability. Mark either "Yes" or "No" for each of the questions listed. At the end of each category, mark how many answers you marked YES. Do your best to be as honest as possible, and your answers will dictate the strategies we use going forward. You will see duplicates of questions. That is intentional. Please do your best to answer as consistently and honestly as possible.

Category 1 (MCP):	**Yes**	**No**
1. I get headaches.		
2. I struggle with depression.		
3. I have cold hand & feet.		
4. I do not eat green leafy vegetables daily.		
5. Eating leafy greens makes me feel better.		
6. I excessively sweat when exercising.		
7. I occasionally get exercise-induced asthma.		
8. I have been diagnosed with hypothyroid.		
9. I do not tolerate alcohol well.		
10. I have a hair-trigger temper.		
11. I am often irritable.		
12. I have mood swings between depression and irritability.		
13. I feel generally tired.		
14. I have difficulty falling asleep.		
15. When I get irritated, I need some time to cool off.		
16. I get shortness of breath.		
17. One or more of my children are on the autism spectrum or have Down's syndrome.		
18. I suffer from menstrual cramping and have noticed clotting in my menstrual fluid.		
19. I have high homocysteine levels.		
20. I have high folate or B_{12} levels.		
Category 1 Score:	/20	
Category 2 (PC)	**Yes**	**No**
1. I have high blood pressure (just for reference, 120/80 is normal).		
2. I have cold hands and feet.		
3. I've noticed my memory has begun to fade.		
4. I have been diagnosed with Type II Diabetes Mellitus.		
5. I am asthmatic.		
6. I have mood swings.		
7. I have an autoimmune condition.		

	Yes	No
8. I know I am chronically inflamed.		
9. I have a family/personal history of heart attacks.		
10. I have a family/personal history of strokes.		
11. I have a family/personal history of atherosclerosis.		
12. I was diagnosed with preeclampsia while pregnant.		
13. I am a mouth-breather.		
14. I heal slowly following an injury or surgery.		
Category 2 Score:	/14	
Category 3 (LDCM)	**Yes**	**No**
1. I have generalized muscle pain.		
2. I am a vegan/vegetarian, or I do not eat beef, eggs, poultry, pork, or organ meats.		
3. I have had my gall bladder removed.		
4. My estrogen levels are low.		
5. I have a heavy metal toxicity.		
6. I have a history of gall stones.		
7. I have a personal/family history of fatty liver disease.		
8. I do not tolerate fatty foods well.		
9. I take antacids.		
10. I notice I have pain in the upper-right quadrant of my abdomen.		
11. I have pain/tightness in my right shoulder, by the scapula.		
12. I have a previous or current diagnosis of Small Intestinal Bacterial Overgrowth (also known as SIBO).		
13. I am postmenopausal.		
14. I do not eat many green leafy vegetables.		
15. My hair went gray at an early age.		
16. I have a history of asthma, diabetes, an autoimmune disease, inflammatory bowel disease, eczema, psoriasis, or another chronic condition.		
17. Following intense exercise, I feel better.		
18. Following a session in a hot sauna, I feel better.		
19. I gain weight even when I am eating right.		
20. I suffer from a neurological disorder.		
21. I am sensitive to chemicals and/or other smells.		
22. I know I have chronic inflammation.		
23. I have an autoimmune disease.		
Category 3 Score:	/23	
Category 4 (DCD)	**Yes**	**No**
1. I get headaches.		
2. I struggle with focusing or remaining attentive.		
3. I have the ability to work hard for weeks at a time, but feel sluggish after and need time to recover.		
4. When it is dark or during the winter, I am especially irritable.		
5. I have been told I have seasonal affective disorder.		
6. I am easily irritable.		
7. I have heavy menstrual bleeding.		

	Yes	No
8. I have trouble falling asleep.		
9. Eating a high-protein diet makes me feel worse.		
10. I need coffee to function in the morning.		
11. I have weak bones.		
12. I suffer from PMS.		
13. I feel depressed often.		
14. I am very sensitive to pain.		
15. I have/ have a history of uterine fibroids.		
16. When I get stressed, it is tough for me to wind down.		
17. I feel a rush after eating carbs, but return to a depressive mood fairly quickly thereafter.		
18. I have an addictive personality (spend time on your phone, gaming, smoking, etc.).		
19. I have an autoimmune disorder.		
20. I tend to worry often.		
21. I lack true motivation.		
22. I have or have a history of:		
23. I have or have a history of Bipolar disorder or panic disorder.		
24. I have or have a history of ADHD.		
25. I have or have a history of Fibroids.		
26. I have or have a history of Uterine cancer.		
27. I have or have a history of Schizophrenia		
28. I have or have a history of PMS.		
29. I have or have a history of Preeclampsia.		
30. I have or have a history of Depression.		
31. I have or have a history of Learning disabilities.		
32. I have or have a history of Parkinson's disease		
33. I have or have a history of Fibromyalgia.		
34. I have or have a history of addictive personality.		
35. I easily get stressed out, am anxious, or panicked.		
36. I fall asleep early.		
37. I wake up earlier than I would like to.		
38. I can focus for long periods of time.		
39. I feel like my heart rate rises and I hyperventilate/breathe faster when I am stressed out.		
40. I like to eat cheese/chocolate and/or drink wine, but do not feel 100% after consuming them.		
41. I often get migraines or headaches.		
42. I feel like I am addicted to carbohydrates.		
43. My focus and attention is unaffected following a carbohydrate-heavy meal.		
Category 4 Score:	/43	
Category 5 (AHR)	**Yes**	**No**
1. I am sensitive to alcohol, especially red wine.		
2. I am sensitive or allergic to many foods.		
3. I feel hot or irritable following eating.		

	Yes	No
4. I get random intermittent joint pains.		
5. I do not tolerate fermented foods, like yogurt, kimchi, or sauerkraut well.		
6. I do not tolerate gluten well.		
7. I do not tolerate dairy well.		
8. I do not tolerate shellfish well.		
9. I do not tolerate chocolate well.		
10. I often take antihistamines.		
11. I do not tolerate most probiotics well.		
12. I react negatively to many different types of foods.		
13. Sometimes I get tinnitus (ringing in the ears) following a meal.		
14. I have a previous or current diagnosis of Small Intestinal Bacterial Overgrowth (also known as SIBO).		
15. I frequently get heartburn.		
16. I frequently take antacids.		
17. I have a history of asthma or have trouble breathing.		
18. I have been diagnosed with ulcerative colitis.		
19. I noticed side effects from medications like NSAIDs, metformin, and antacids.		
20. I feel better 2-3 hours following eating.		
21. I get diarrhea for no particular reason from time to time.		
22. I have trouble falling or staying asleep.		
23. I suffer from exercise-induced asthma.		
24. My eyes itch often.		
25. I often get carsick/seasick.		
26. I frequently feel dizzy.		
27. I do not feel great in the 20 minutes or so following a meal.		
Category 5 Score:	/26	