Gastrointestinal (GI) Health Assessment

The GI system is quite complex,and evaluating GI health in order to recommend a therapeutic support program can be a difficultundertaking in a busy practice.To simplify matters,the following graph provides aquick scoring system for GI Health as assessed by the Health Appraisal Questionnaire

SECTION A

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | LOW PRIORITY | MODERATE PRIORITY | HIGH PRIORITY |  |  |
| GASTRIC FUNCTION |  1 2 3 4 |  5 6 7 8 |  20 32 44 56 |  |  |
| GI INFLAMMATION |  1 2 3 4 |  5 6 7 8 |  24 40 56 72 |  |  |
| SMALL INTESTINES AND PANCREAS |  2 4 6 8  |  10 12 14 16 |  32 48 64 80 |  |  |
| COLON |  2 4 6 8  |  10 12 14 16 | 30 44 58 72 |  |  |

SECTION B

SECTION C

SECTION D

 INTIAL RETEST

**SECTION A**

**1.** Indigestion, food repeats on you after you eat 0 1 4 8

**2.** Excessive burping, belching and/or bloating

following meals 0 1 4 8

**3**. Stomach spasms and cramping during or

 after eating 0 1 4 8 **4.** A sensation that food just sits in your stomach

 creating uncomfortable fullness, pressure and

bloating during or after a meal 0 1 4 8 **5.** Bad taste in your mouth 0 1 4 8 **6.** Small amounts of food fill you up immediately 0 1 4 8 **7.** Skip meals or eat erratically because you have

 no appetite 0 1 4 8

**TOTAL SECTION A:\_\_\_\_\_\_\_**

**SECTION B**

**1**.Strong emotions, or the thought or smell of

food aggravates your stomach or makes it hurt0 1 4 8 **2.** Feel hungry an hour or two after eating a

good-sized meal 0 1 4 8 **3**. Stomach pain, burning and/or aching over a

period of 1-4 hours after eating0 1 4 8 **4.** Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids0 1 4 8 **5.** Burning sensation in the lower part of your

chest, especially when lying down or bending

forward 0 1 4 8 **6.** Digestive problems that subside with rest

and relaxation(0)No (8)Yes

**7.** Eating spicy and fatty (fried) foods,

chocolate, coffee, alcohol, citrus or hot

peppers causes your stomach to burn or ache0 1 4 8 **8.** Feel a sense of nausea when you eat0 1 4 8 **9.** Difficulty or pain when swallowing food or

beverage 0 1 4 8

**TOTAL SECTION B­­­\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **NEVER** | **OCCASSIONALLY** | **OFTEN** | **F****R****EQUENT****L****Y** |

|  |  |  |  |
| --- | --- | --- | --- |
| **NEVER** | **OCCA****S****S****I****O****N****ALLY** | **OFTEN** | **F****R****E****Q****U****E****N****T****L****Y** |

GI HEALTH APPRAISAL QUESTIONNAIRE

DIRECTIONS This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

**For each question, circle the number that best describes your symptoms:**

**0**= No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

**1**= Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

**4** = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

**8** = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

**Some questions require a YES or NO response:** **0= NO 8= YES**

**SECTION C**

**1.** When massaging under your rib cage on your left

 side, there is pain, tenderness or soreness 0 1 4 8 **2.** Indigestion, fullness or tension in your abdomen

is delayed, occurring 2-4 hours after eating a meal 0 1 4 8 **3**. Lower abdominal discomfort is relieved with

the passage of gas or with a bowel movement 0 1 4 8

**4.** Specific foods/beverages aggravate indigestion 0 1 4 8 **5.** The consistency or form of your stool changes

(e.g., from narrow to loose) within the course of a

day 0 1 4 8 **6.** Stool odor is embarrassing 0 1 4 8 **7.** Undigested food in your stool 0 1 4 8

**8**. Three or more large bowel movements daily 0 1 4 8

**9.** Diarrhea (frequent loose, watery stool) 0 1 4 8

**10**. Bowel movement shortly after eating

(within 1 hour) 0 1 4 8

**TOTAL SECTION C:\_\_\_\_\_\_\_\_­\_\_\_\_**

**SECTION D**

**1**.Discomfort, pain or cramps in your colon

(lower abdominal area) 0 1 4 8

**2.** Emotional stress and/or eating raw fruits

and vegetables causes abdominal bloating, pain,

cramps or gas0 1 4 8

**3.** Generally constipated (or straining during

bowel movements) 0 1 4 8

**4.** Stool is small, hard and dry0 1 4 8

**5.** Pass mucus in your stool 0 1 4 8

**6.** Alternate between constipation and

diarrhea 0 1 4 8 **7.** Rectal pain, itching or cramping0 1 4 8

**8.** No urge to have a bowel movement 0 1 4 8

**9.** An almost continual need to have a bowel

movement0 1 4 8

**TOTAL SECTION D­­­\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **NEVER** | **OCCASSIONALLY** | **OFTEN** | **F****R****EQUENT****L****Y** |

|  |  |  |  |
| --- | --- | --- | --- |
| **NEVER** | **OCCA****S****S****I****O****N****ALLY** | **OFTEN** | **F****R****E****Q****U****E****N****T****L****Y** |

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