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Symptoms Inventory for Food Allergy-Sensitivity

Date Wellness Program started: **Followed Wellness Program: Exactly Mostly Hardly Never**

Enter Total Score (total of all totals) and use to compare with future inventory:

Symptom (Sx) Scale: 1=Never 2=Occasionally 3=Occasionally w/ severe Sx 4=Frequently 5=Frequently w/ severe Sx							
	HEAD		**EARS**		**NOSE**		**EYES**
	Headaches		Itchy		Stuffy		Watery
	Dizziness		Earaches/Infections		Red/Inflamed		Itchy
	Sleep disorders		Ringing in ears		Sinus problems		Red/Swollen
	Face flushing		Hearing loss		Hay fever		Dark circles
			Reddening of ears		Sneezing		Blurry vision
	TOTAL		**TOTAL**		**TOTAL**		**TOTAL**
	MOUTH & THROAT		**SKIN**		**DIGESTION**		**ENERGY**
	Chronic cough		Acne		Nausea		Lethargic
	Clear throat often		Itching		Diarrhea		Fatigue
	Sore throat		Hives/Rash		Constipation		Hyperactive
	Swollen Lips		Dry skin		Bloated feeling		Restlessness
	Canker sores		Hot flashes		Stomach		
	Itching				Vomiting		
	Hoarse/Loss voice				Blood/Mucus in stool		
	TOTAL		**TOTAL**		**TOTAL**		**TOTAL**
	MUSCLE & JOINTS		**EMOTIONS**		**WEIGHT**		**MIND**
	Arthritis		Mood swings		Underweight		Poor memory
	Stiffness		Anxiety/fear		Binge eating		Learning disabilities
	Pain/Ache in joints		Irritable/aggressive		Craving certain foods		Difficulty completing a task
	Pain/Ache in muscles		Cries easily		Compulsive eating		Short attention span
	Weak or tired		Depressed		Overweight		Confusion
	Growing pains				Water retention		
	TOTAL		**TOTAL**		**TOTAL**		**TOTAL**
	HEART		**LUNGS**				
	Irregular		Congestion				
	Rapid		Persistent cough				
	Chest pain		Asthma/Bronchitis				
	Chest pounding		Shortness of breath				
			Wheezing				
	TOTAL		**TOTAL**				