



THE FOOD SENSITIVITY SCALE

DIRECTIONS: On a scale of 0-2, give every single symptom a number for how often you have it.

0 = NEVER

1 = ONCE A WEEK

2 = SEVERAL TIMES A WEEK

QUESTION 1

ON A SCALE OF 0-2 HOW OFTEN DO YOU EXPERIENCE THE FOLLOWING HEAD & MOOD SYMPTOMS:

HEADACHE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
TROUBLE CONCENTRATING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
ANXIETY	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
DEPRESSION	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

QUESTION 2

ON A SCALE OF 0-2 HOW OFTEN DO YOU EXPERIENCE THE FOLLOWING SENSITIVITY SYMPTOMS IN YOUR MID-SECTION:

BLOATING	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
GAS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
CONSTIPATION	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
DIARRHEA	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

QUESTION 3

ON A SCALE OF 0-2 HOW OFTEN DO YOU EXPERIENCE THESE TOP TO BOTTOM SENSITIVITY SYMPTOMS:

EXHAUSTION	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
FATIGUE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
ACHING JOINTS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
SKIN RASH	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

ADD UP ALL 12 NUMBERS.
YOUR FINAL NUMBER SHOULD BE
SOMEWHERE BETWEEN 0 AND 24.

TOTAL: