SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC
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Digestion Questionnaire

Patient's Name _____ **DOB** _____ **Date** _____

Symptoms Checklist

Enter your scores into the appropriate categories in the chart.

Rate the frequency and severity of your symptoms:

0 =Never have the symptom
1= Occasionally experience mild symptoms
2 = Occasionally experience severe symptoms
3 = Frequently experience mild symptoms
4 = Frequently experience severe symptoms

Digestive Tract	AM	N	PM
Belching			
Bloated Feeling			
Constipation			
Diarrhea			
Nausea			
Gas			
Smelly Stools/ Mucous in Stools			
Stomach Pains			
Total			

Skin	AM	N	PM
Acne			
Dermatitis			
Dry Skin			
Eczema			
Hair Loss			
Itching			
Excessive Sweating/ Flushing/Hot Flashes			
Hives/Rashes			
Total			

Mouth & Throat	AM	N	PM
Canker Sores			
Chronic Coughing			
Gagging			
Receeding Gums			
Sore Throat			
Swollen Tonsils			
Swollen Tongue/ Lips/Gums			
Total			

Nose	AM	N	PM
Excessive Mucous			
Hay Fever			
Post-Nasal Drip			
Sinus Problems			
Sneezing Attacks			
Stuffy Nose			
Total			

Mind	AM	N	PM
Brain Fog			
Focus			
Poor Concentration			
Poor Memory			
Stuttering/ Stammering			
Total			

Mood	AM	N	PM
Aggressiveness			
Anxiety/Fear			
Depression			
Mood Swings			
Nervousness			
Irritability/ Anger			
Total			

Joints & Muscles	AM	N	PM
Achy Muscles			
Arthritis			
Joint Pain			
Stiffness			
Weakness			
Limited Joint Movement			
Total			

Eyes	AM	N	PM
Blurred Vision			
Dark Circles			
Itchy Eyes			
Swollen Eyes			
Watery Eyes			
Sticky/Crusty Eyelids			
Total			

Energy & Activity	AM	N	PM
Apathy			
Fatigue			
Hyperactivity			
Insomnia			
Restlessness			
Total			

Ears	AM	N	PM
Drainage			
Ear Aches			
Ear Infections			
Itchy Ears			
Ringing in Ears			
Total			

Head	AM	N	PM
Dandruff			
Dizziness			
Headaches			
Lightheadedness			
Migraines			
Total			

Lungs	AM	N	PM
Asthma/Bronchitis			
Congestion			
Difficulty Breathing			
Shortness of Breath			
Wheezing			
Total			

Weight	AM	N	PM
Binge Eating			
Compulsive Eating			
Food Cravings			
Underweight			
Weight Gain			
Total			

Other	AM	N	PM
Chest Pains			
Frequent Illness			
Rapid Heartbeat			
Urgent Urination			
Total			

For FEMALE patients:

Are you currently taking any oral contraceptive pills? ☐ YES ☐ NO

If yes: Which prescription are you using, and for how long? _____