Heal Your Digestion Assessment

Name:____ Date: ___________

Point Scale:
0 = Never or almost never have the experience/effect.
1 = Mild experiences/effects
2 = Moderate experiences/effects
3 = Severe/chronic experiences/effects
For all yes/no questions, 0 = no and 3 = yes

Upper Gastrointestinal - low stomach acid/digestive enzymes	**0**	**1**	**2**	**3**
Do you experience belching or gas within one hour after eating?				
Do you experience heartburn or acid reflux?				
Do you experience bloating within one hour after eating?				
Do you have bad breath?				
Do you have a loss of taste for meat?				
Does your sweat have a strong odor?				
Do you experience stomach upset by taking vitamins?				
Do you feel a sense of excess fullness after meals?				
Do you feel better if you don't eat?				
Do you feel sleepy after meals?				
Do your fingernails chip, peel or break easily?				
Do you have anemia (low red blood cells count) that is unresponsive to iron?				
Do you experience stomach pains or cramps?				
Do you have chronic diarrhea?				
Do you experience diarrhea shortly after meals?				
Is there ever undigested food in your stool?				

©Robin Nielsen

Subtotal for Upper Gastrointestinal Symptoms – low stomach acid (sum of cores)				
Subtotal /48				

Upper Gastrointestinal - excess stomach acid	0	1	2	3
Do you ever have black or tarry colored stools?				
Do you experience stomach pain, burning or aching 1-4 hours after eating?				
Do you use antacids?				
Do you ever feel hungry an hour to two hours after eating?				
Do you experience heartburn from spicy foods, chocolate, citrus, peppers, alcohol, and/or caffeine?				
Do you receive temporary heartburn relief from antacids, food, milk or carbonated beverages?				
Do your digestive problems subside with rest and relaxation?				
Subtotal for Upper Gastrointestinal Symptoms – excess stomach acid (sum of scores)				
Subtotal /21				

Liver and Gallbladder	0	1	2	3
Do you experience pain between your shoulder blades?				
Do you experience stomach upset by eating greasy foods?				
Do you ever have greasy or shiny stools?				
Do you experience nausea or motion sickness (sea, car, or airplane)				
Do you have a history of morning sickness? 0 = never, 1 = years ago, 2 = within last year,3 = within past 3 months				
Do you ever have light or clay colored stools?				
Do you have dry skin, itchy feet, or skin peels on your feet?				

©Robin Nielsen

Question				
Do you ever feel headaches "over your eyes"?				
Have you ever had a gallbladder attack(s)? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months				
Has your gallbladder been removed?				
Do you ever experience a bitter taste in your mouth, especially after meals?				
Would you become sick or easily intoxicated if you were to drink alcohol?				
Would you be easily hung over if you were to drink alcohol?				
Are you a recovering alcoholic?				
How many alcoholic drinks do you consume per week? 0 = <3, 1 = <7, 2 = <14, 3 = >=14				
Do you have a history of drug or alcohol abuse? 0 = never, 1 = years ago, 2 = within last year,3 = within past 3 months				
Do you have a history of hepatitis? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months				
Are you sensitive to chemicals?				
Do you have a history of long term use of prescription/recreational drugs? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months				
Are you sensitive to tobacco smoke?				
Are you sensitive when exposed to diesel fumes?				
Do you ever feel pain under the right side of your rib cage?				
Do you have hemorrhoids or varicose veins?				
Do you consume NutraSweet (aspartame)?				
Are you sensitive to NutraSweet (aspartame)?				
Do you have chronic fatigue or Fibromyalgia?				
Do you have lower bowel gas and/or bloating several hours after eating?				
Is there a yellowish cast to your eyes?				

©Robin Nielsen

Do you have reddened skin, especially your palms?				
Subtotal for Liver and Gallbladder Symptoms (sum of scores)				
Subtotal /90				

Small Intestine and Pancreas	**0**	**1**	**2**	**3**
Do you have any known food allergies?				
Do you experience abdominal bloating 1 to 2 hours after eating?				
Do specific foods make you tired or bloated?				
Does your pulse increase after eating?				
Do you have any airborne allergies?				
Do you experience hives?				
Do you experience sinus congestion or "stuffy head"?				
Do you crave bread or noodles?				
Do you alternate between constipation and diarrhea?				
Do you have a history of Crohn's disease? 0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months				
Are you sensitive to wheat or grains?				
Are you sensitive to dairy?				
Are there foods you could not give up?				
Do you have issues with asthma, sinus infections, and/or a stuffy nose?				
Do you have bizarre, vivid dreams and/or nightmares?				
Do you use over-the-counter pain medications?				
Do you ever feel spacey or unreal?				
Does eating roughage and fiber cause constipation?				
Do you have indigestion and fullness that lasts 2-4 hours after eating?				

©Robin Nielsen

Do you ever feel pain, tenderness, soreness on your left side under your rib cage?				
Do you experience excessive passage of gas?				
Do you experience nausea and/or vomiting?				
Do you notice your stool is undigested, foul smelling, mucous-like, greasy, and/or poorly formed?				
Do you frequently need to urinate?				
Do you have an intense thirst and appetite?				
Do you have difficulty losing weight?				
Subtotal for Small Intestine and Pancreas Symptoms (sum of scores)				
Subtotal /78				

Large Intestine	**0**	**1**	**2**	**3**
Do you ever have issues with your anus being itchy?				
Is your tongue coated?				
Do you feel worse in moldy or musty places?				
Have you taken antibiotics for a total accumulated time of: 0 = never, 1 = <1 month, 2 = <3 months, 3 = >3 months				
Do you ever have fungus or yeast infections?				
Do you have ringworm, "jock itch", "athletes foot", and/or nail fungus?				
Do any yeast related symptoms increase with sugar, starch or alcohol?				
Are your stools hard or difficult to pass?				
Do you have a history of parasites? 0 = never, 1 = <1 month, 2 = <3 months, 3 = >3 months				
Do you have less than one bowel movement per day?				
Do your stools ever have: corners, edges, flat shapes, ribbon shapes				

©Robin Nielsen

Question				
Are your stools not well formed (loose)?				
Do you have irritable bowel or mucus colitis?				
Do you ever have blood in your stool?				
Do you ever have mucus in your stool?				
Do you ever have excessive foul smelling lower bowel gas?				
Do you have bad breath or strong body odors?				
Is it painful to press along the outer sides of your thighs (Iliotibial Band)?				
Do you have cramping in your lower abdominal region?				
Do you have dark circles under your eyes?				
Do you ever have the feeling that your bowels do not empty completely?				
Do you experience lower abdominal pain relief by passing stool or gas?				
Do you have alternating constipation and diarrhea?				
Do you ever experience diarrhea?				
Do you ever experience constipation?				
Do you have more than 3 bowel movements daily?				
Do you ever have a need for laxatives?				
Subtotal for Large Intestine Symptoms (sum of scores)				
Subtotal /81				
Grand Total (sum of the five Subtotals) /327				

Interpretation

Be sure to complete this in full **BEFORE the workshop**. Robin will help you understand what your score means and how to address the symptoms that you may be experiencing. You can heal! xo

©Robin Nielsen