Food Sensitivity/Intolerance Questionnaire

Name:____ Date:_____________

(Please Circle Y for yes, N for no)

Y N Do you feel uncomfortable if you are late for or miss a meal, i.e. do you get a headache, fatigue, weakness, depression, irritability, etc.?

Y N Do you feel uncomfortable after a meal?

Y N Do you get relief from these discomforts if you eat?

Y N Is supper/dinner incomplete if you do not have a specific food with it every night?

Y N Do you go on eating binges or food jags?

Y N Do you use ketchup and/or mustard on most of your food? or relish? or vinegar?

Y N Do you have to make certain that you have a particular food each day

Y N Do you need something sweet in the house at all times?

Y N Are you afraid you will run out of a particular food or sweet?

Y N Do you have trouble facing the day without a donut or two, or without some particular food or beverage in the morning?

Y N Do you have to eat bread, drink milk or coffee, or have some special food or beverage every day for lunch or at dinner time or as a snack between meals or late at night?

Y N Do you crave pizza, pancakes, cookies, cake, pretzels, spaghetti, or macaroni?

Y N Do you have to eat a dish of ice cream or something else before going to bed in order to sleep well?

Y N Do you insist on eating potatoes, wheat or corn in some form every day?

Y N Do you feel there are some foods you could not live without?

Y N Do you find it impossible to stick to a diet?

Y N Do you feel like you are a "junk food junkie"?

Y N Do you hide certain foods in different places so you can always get at it?

Y N Do you feel you still need to eat because you don't feel right even though even when full?

* A high number of yes answers (greater than 7) suggests the possibility of food sensitivities or intolerances. Please bring this questionnaire back to the doctor’s office for interpretation.