



**Your doctor wants you to know that if you have one or more of these symptoms, there's a 95% probability you'll benefit from a food toxicity test.**

Please place a checkmark at each of your symptoms and return the completed checklist to your physician. Be certain to include symptoms that you've "learned to live with."

**Digestive Tract**

- Diarrhea
- Constipation
- Bloating feeling
- Belching
- Passing gas
- Stomach pains

**Energy & Activity**

- Fatigue
- Sluggishness
- Apathy
- Hyperactivity
- Restlessness
- Lethargy

**Joint & Muscles**

- Pain in joints
- Arthritis
- Stiffness
- Limited movement
- Aches in muscles
- Feeling of weakness

**Skin**

- Acne
- Hives, rashes
- Hair loss
- Flushing/hot flashes
- Excessive sweating

**Ears**

- Itchy ears
- Ear aches
- Ear infections
- Drainage from ear
- Ringing in ears
- Hearing loss

**Eyes**

- Watery eyes
- Itchy eyes
- Swollen eyelids
- Sticky eyelids
- Dark circles
- Blurred vision

**Mouth & Throat**

- Chronic coughing
- Gagging
- Often clear throat
- Sore throat
- Swollen tongue/lips
- Canker sores

**Lungs**

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing

**Emotions**

- Mood swings
- Anxiety, fear
- Irritability, anger
- Depression
- Aggressiveness
- Nervousness

**Weight**

- Binge eating
- Cravings
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

**Nose**

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucous

**Mind**

- Poor memory
- Confusion
- Poor concentration
- Stuttering/stammering
- Learning disabilities

**Head**

- Headaches
- Faintness
- Dizziness
- Insomnia

**Other**

- Irregular heartbeat
- Rapid heartbeat
- Chest pains
- Frequent illness
- Urgent urination
- Genital itch

**Patient Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_