# *Immune Response Questionnaire*

**Name** **Date**

INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints. Leave the question blank if it does not apply to you.
0 = RARELY OR NEVER EXPERIENCE SYMPTOM 1 = MILD 2 = MODERATE 3 = SEVERE

## PART 1: Immune Function

**Section A:**

| | | |
|---|---|---|
| 1 | Chronic swollen lymph glands | 0 1 2 3 |
| 2 | Frequent sore throats | 0 1 2 3 |
| 3 | Experience ear infections | 0 1 2 3 |
| 4 | Cold sores or fever blisters | 0 1 2 3 |
| 5 | Chronic low grade fever | 0 1 2 3 |
| 6 | Gums and/or nose bleeds easily | 0 1 2 3 |
| 7 | Experience frequent runny nose | 0 1 2 3 |
| 8 | Muscle aches and joint pain | 0 1 2 3 |
| 9 | Frequently tired or fatigued unrelieved by sleep | 0 1 2 3 |
| 10 | Easily susceptible to infections | 0 1 2 3 |
| 11 | Frequently catch a cold or flu (Press 0 for NO, 1 for YES) | NO YES |
| 12 | Difficult to recuperate from a flu or cold (Press 0 for NO, 1 for YES) | NO YES |
| 13 | Cuts or bruises heal slowly (Press 0 for NO, 1 for YES) | NO YES |
| 14 | Hair grows slowly or falls out easily (Press 0 for NO, 1 for YES) | NO YES |

**Section B:**

| | | |
|---|---|---|
| 1 | Experience chemical sensitivities | 0 1 2 3 |
| 2 | Experience environmental and/or food allergies | 0 1 2 3 |
| 3 | Irritability/mood swings | 0 1 2 3 |
| 4 | Frequent headaches and/or migraines | 0 1 2 3 |
| 5 | Abnormal fatigue not helped by rest | 0 1 2 3 |
| 6 | Post nasal drip | 0 1 2 3 |
| 7 | Frequent sneezing attacks and/or hayfever | 0 1 2 3 |
| 8 | Weight fluctuations of 4-5 lbs. in one day accompanied by puffiness in face/ankles/fingers | 0 1 2 3 |
| 9 | Chronic muscle aches and pains | 0 1 2 3 |
| 10 | Suffer from asthma/breathing difficulties | 0 1 2 3 |
| 11 | Eczema, hives or skin rashes | 0 1 2 3 |
| 12 | Suffer from depression or crying spells | 0 1 2 3 |
| 13 | Itchy eyes or nose | 0 1 2 3 |
| 14 | Chronic runny nose | 0 1 2 3 |
| 15 | Chronic stuffy nose | 0 1 2 3 |
| 16 | Dark circles under your eyes | 0 1 2 3 |
| 17 | Frequent urination or bedwetting | 0 1 2 3 |
| 18 | Swelling in joints | 0 1 2 3 |
| 19 | Mouth or throat itches | 0 1 2 3 |
| 20 | Chronic lymph gland swelling, especially in the throat area | 0 1 2 3 |
| 21 | Acne | 0 1 2 3 |
| 22 | Sweat for no apparent reason / hot flashes | 0 1 2 3 |
| 23 | Certain foods cause you to have a reaction (jitters, depression, ill feelings, etc.) | 0 1 2 3 |
| 24 | Strong cravings for certain foods | 0 1 2 3 |
| 25 | Pulse races after eating certain foods or for no apparent reason | 0 1 2 3 |
| 26 | Mucous in stool | 0 1 2 3 |
| 27 | Minor, chronic complaints that always reoccur | 0 1 2 3 |
| 28 | Feel best when you do not eat | 0 1 2 3 |
| 29 | Hyperactive | 0 1 2 3 |
| 30 | Abdominal pain after eating | 0 1 2 3 |
| 31 | Alternating diarrhea/constipation | 0 1 2 3 |
| 32 | Suffer from irritable bowel, spastic colon or colitis (Press 0 for NO, 1 for YES) | NO YES |

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**Section C:**

| | | |
|---|---|---|
| 1 | Chronic fatigue, especially after eating | 0 1 2 3 |
| 2 | Depression | 0 1 2 3 |
| 3 | Recurrent digestive complaints | 0 1 2 3 |
| 4 | Rectal itching | 0 1 2 3 |
| 5 | Experience food and/or environmental allergies | 0 1 2 3 |
| 6 | Feel "spacey" | 0 1 2 3 |
| 7 | Poor memory | 0 1 2 3 |
| 8 | Severe mood swings | 0 1 2 3 |
| 9 | Anxiety/nervousness | 0 1 2 3 |
| 10 | Recurrent fungal infections (athletes foot, ringworm, "jock itch") | 0 1 2 3 |
| 11 | Experience extreme chemical sensitivity | 0 1 2 3 |
| 12 | Coated or sore tongue | 0 1 2 3 |
| 13 | Light-headedness or feel drunk after minimal wine, beer or certain foods | 0 1 2 3 |
| 14 | Respiratory problems | 0 1 2 3 |
| 15 | Chronic skin rashes or acne | 0 1 2 3 |
| 16 | Thrush (white fungus in mouth or vagina) | 0 1 2 3 |
| 17 | Headaches/migraines | 0 1 2 3 |
| 18 | Muscle and joint pains | 0 1 2 3 |
| 19 | Low blood sugar | 0 1 2 3 |
| 20 | Crave sugar, breads or alcoholic beverages | 0 1 2 3 |
| 21 | Suffer from PMS | 0 1 2 3 |
| 22 | Cannot tolerate perfumes or smoke | 0 1 2 3 |
| 23 | Prostatitis (Press 0 for NO, 1 for YES) | NO YES |
| 24 | Recurrent vaginal or urinary infections (Press 0 for NO, 1 for YES) | NO YES |
| 25 | Loss of libido/impotence (Press 0 for NO, 1 for YES) | NO YES |
| 26 | History of frequent antibiotic use (Press 0 for NO, 1 for YES) | NO YES |
| 27 | Taking or have taken birth control pills (Press 0 for NO, 1 for YES) | NO YES |
| 28 | Endometriosis and/or infertility (Press 0 for NO, 1 for YES) | NO YES |
| 29 | Above conditions get worse in moldy places like basements or damp climates (Press 0 for NO, 1 for YES) | NO YES |
| 30 | Above conditions get worse after eating or drinking items that contain yeast or sugar (Press 0 for NO, 1 for YES) | NO YES |

**Section D:**

| | | |
|---|---|---|
| 1 | Fatigue | 0 1 2 3 |
| 2 | Depression | 0 1 2 3 |
| 3 | Anxiety, nervousness and/or irritability | 0 1 2 3 |
| 4 | High blood pressure | 0 1 2 3 |
| 5 | Headaches | 0 1 2 3 |
| 6 | Digestive problems (colic, nausea, pain) | 0 1 2 3 |
| 7 | Numbness/tingling/tremors | 0 1 2 3 |
| 8 | Skin problems (rashes, eczema, psoriasis) | 0 1 2 3 |
| 9 | Ringing in your ears | 0 1 2 3 |
| 10 | Muscle and joint pain | 0 1 2 3 |
| 11 | Allergies/asthma | 0 1 2 3 |
| 12 | Kidney and/or liver problems | 0 1 2 3 |
| 13 | Constipation | 0 1 2 3 |
| 14 | Memory problems | 0 1 2 3 |
| 15 | Varied symptoms with no relief | 0 1 2 3 |
| 16 | Increased susceptibility to infections (Press 0 for NO, 1 for YES) | NO YES |
| 17 | Learning disabilities (Press 0 for NO, 1 for YES) | NO YES |
| 18 | Anemia (Press 0 for NO, 1 for YES) | NO YES |