Name: _____

Date: _____

FOOD TOLERANCE TESTING	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15
poor concentration															
headache															
joint pain															
poor immune function															
skin rashes															
swelling/dark u. eyes															
itchy mouth															
hoarse/scratchy throat															
sinus +/nasal congestion															
ear pain or congestion															
abdominal pain															
abdominal gas															
loose bowel/constipation															
fatigue															
elevated pulse rate															

TO USE THIS CHART:

1. RATE YOUR SYMPTOMS FROM 0 (NON-EXISTENT) TO 5 (SEVERE).
2. IN COLUMN #1, RATE YOUR SYMPTOMS BEFORE STARTING THE ELIMINATION DIET.
3. IN COLUMN #2, RATE YOUR SYMPTOM AT THE END OF THE ELIMINATION PERIOD, for example day 10.
4. USE THE REMAINING COLUMNS TO RATE HOW YOUR SYMPTOMS RESPOND AFTER ADDING IN THE TEST FOOD.