

Symptom Rating Worksheet

Date: _____

This week's challenge or elimination, if any:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Sum
Diarrhea								
Urgency								
Constipation								
Pain/cramps								
Bloating								
Gas								

Rate the impact of the symptoms on a scale of 0-3:

0=no or transient symptoms

1=mild; occasional episodes of short duration

2=moderate; frequent episodes of prolonged discomfort interfering with some social activities or work (for urgency, 2=frequent sudden need for toilet)

3=severe; prolonged episodes with only transient relief, seriously interfering with social performance or work (for urgency, 3=unable to control bowels)

For "diarrhea" note the total number of bowel movements for the entire 24-hour period.

At the end of the week, add up your score for each symptom and write the number in the column marked, "Sum."

Comments: