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Name: _____ Date: _____

Main Complaints:

1) _____ 2) _____

3) _____ 4) _____

How long have you suffered from this problem? _____Is the prorgam

helping or improving your symptoms. …….. yes or no.

If yes, how much……..

If not, why……..

Any other complaints: _____

Would you like improvement with any of the following?

Digestion: Reflux, Gas, Constipation

Sleep: Falling asleep or staying asleep

Sense of Well Being

Energy

___

Nutrition and Gut Symptoms Questionnaire

Please complete the following to help us understand your digestion, nutrition, and gut health.

Digestion

Do you experience bloating or abdominal distension? □ Yes □ No Frequency: _____

Do you have reflux, heartburn, or a sour taste in your mouth? □ Yes □ No

Do you experience nausea after eating? □ Yes □ No

Do you have constipation (less than one bowel movement per day)? □ Yes □ No

Do you have diarrhea or loose stools? □ Yes □ No

Do you notice undigested food in your stool? □ Yes □ No

Do you have excessive gas or belching? □ Yes □ No

Do you experience abdominal pain or cramping? □ Yes □ No

Bowel Health

How many bowel movements do you have per day? _____

What is the consistency of your stool? (Please circle) Hard | Formed | Soft | Loose | Watery

Do you notice mucus or blood in your stool? □ Yes □ No

Do you feel completely emptied after a bowel movement? □ Yes □ No

Eating Habits

How many meals do you eat per day? _____

Do you skip meals? □ Yes □ No If yes, which ones? _____

Do you eat late at night? □ Yes □ No

Do you feel better or worse after eating certain foods? Please specify: _____

Do you chew your food thoroughly? □ Yes □ No

Do you often eat on the go or while distracted (TV, work, phone)? □ Yes □ No

Food Intolerances and Allergies

Do you have known food allergies? □ Yes □ No If yes, please list: _____

Do you suspect any food sensitivities or intolerances (e.g., gluten, dairy, eggs)? □ Yes □ No

Do you feel fatigued, congested, or bloated after eating certain foods? □ Yes □ No

Cravings and Appetite

Do you crave sugar or sweets? □ Yes □ No

Do you crave salty foods? □ Yes □ No

Do you drink coffee or caffeinated drinks? □ Yes □ No How many per day? _____

Do you drink alcohol? □ Yes □ No How often? _____

Do you feel hungry soon after eating? □ Yes □ No

Hydration and Supplements

How many glasses of water do you drink per day? _____

Do you drink other beverages regularly (tea, juice, soda, etc.)? □ Yes □ No Please list: _____

Do you take any fiber supplements? □ Yes □ No Brand/Type: _____

Do you take digestive enzymes or probiotics? □ Yes □ No Brand/Type: _____

Symptoms and Overall Well-Being

Do you feel fatigued after meals? □ Yes □ No

Do you experience brain fog or difficulty concentrating after eating? □ Yes □ No

Do you experience mood changes or irritability related to meals? □ Yes □ No

Have you noticed skin issues (acne, rashes, eczema) related to food intake? □ Yes □ No

Do you have unexplained weight gain or loss? □ Yes □ No

Please use the space below for any additional comments or concerns about your digestion or nutrition:

_____

_____

_____

Thank you