Health Solutions
Holistic Center Marietta

Gut Health Assessment Questionnaire

This questionnaire is designed to provide all the information necessary to build **Your Gutway to Health and Happiness Program,** an individualized, Functional Nutrition program specifically tailored to meet your needs. (Please answer the questions as accurately as you can)

Logistics

First Name_____ Last Name_____ Date of Birth_____

Address _____

Phone number _____ E-mail _____

Occupation: _____

General Health Profile

1. **List** your main health issues of concern:

_____

_____

2. **How** have these symptoms negatively impacted your life (eg. work, recreation, relationships, emotional impact)?

_____

_____

3. How would you rate your stress levels on scale of 1-10 (10 being the highest)? _____
4. What stresses you out the most (eg. job, finances, kids, relationships)? _____
5. Do you feel you 'handle' or process life stressors effectively? _____
6. How would you rate the quality of your sleep? _____
7. Do you smoke? Y or N
8. How much physical activity/exercise do you get each week – name of activity and for how long?

_____

9. How much water do you drink per day? Circle type: tap, filtered, bottled, ionized, distilled, hydrogen

_____

10. How much Raw and Green Leafy vegetables do you eat on a weekly basis? _____

11. Do you consume any of the following items at least **1X** per week:

- Dairy
- Bread (of any kind)
- Pizza, Pasta, Rice, Crackers, Chips
- Sweets (chocolate, cake, cookies, candy, doughnuts, pancakes)
- Corn, Soy
- Fruit juice
- Coffee
- Soda
- Alcohol

12. List any allergies you have (seasonal, food, or otherwise):_____

_____

13. Your blood type? (if known) _____

14. List all supplements & herbs **CURRENTLY** taking:

_____

_____

15. List medications **CURRENTLY** taking & what for: _____

_____

16. What do you do for relaxation or tension relief? _____

Gastrointestinal Inflammation

(Check the following that apply to you PAST or PRESENT)

- I eat my meals fast
- I eat under stress (eg. while driving, working, etc.)
- Phlegm or mucus production after eating
- Gas
- Bloating
- Constipation
- I have poorly formed stools (eg. loose, soft, irregular shape)
- I have fewer than 2 bowel movements per day
- I have light-colored and/or foul smelling stools
- Heartburn/Acid Reflux
- SIBO (Small Intestinal Bacterial Overgrowth)
- IBS (Irritable Bowel)
- Diverticulits Chrone's Ulcerative Colitis Celiac disease or Gluten sensitivity
- Autoimmune disease (eg. Rheumatoid Arthrits, MS, Lupus, Ankylosing Spondylitis, Psoriatic Arthritis)
- Candida/Yeast infection
- Skin issues (eg. acne, rash, eczema, psoriasis, dry or scaly skin, dandruff, dark circles under eyes)
- Hair loss
- Difficulty losing weight
- Chronic sinus infection

Neurological:

- Depression Anxiety Mood swings Brain fog Fatigue Forgetful
- Poor concentration Headaches / Migraines

Musculoskeletal:

- Joint pain and/or stiffness Muscle pain Gout Fibromyalgia Chronic Fatigue Syndrome

Medication History: mark if CURRENT, RECENT, or PAST usage

- ANTIBIOTICS
- NSAIDS, Steroids, Predisone
- Acid Reflux/GERD medicines: Tagamet, Zantac, Pepcid, Prilosec, Prevacid

Blood Sugar

- I crave sweets, love carbs
- I have a family history of diabetes, hypoglycemia or alcoholism
- I get irritable, anxious, tired and jittery, or get headaches intermittently throughout the day, but feel better temporarily after meals
- I feel shaky 2-3 hours after a meal
- I eat a low-fat diet
- If i miss a meal, I feel cranky and irritable, weak, or tired
- If I eat a carbohydrate breakfast (muffin, bagel, cereal, pancakes etc.), I can't seem to control my eating for the rest of the day
- Once I start eating sweets or carbohydrates, I want more
- If I eat fish or meat and vegetables, I feel good, but seem to get sleepy after eating a meal full of pasta, bread, potatoes, and dessert
- I go for the breadbasket at restaurants
- I seem salt sensitive (I tend to retain water)
- I am often moody, impatient, or anxious
- I get tired a few hours after eating
- My memory and concentration are poor
- I am tired most of the time
- I have extra weight around the middle
- I have high blood pressure
- I have high Total cholesterol, high LDL cholesterol, high Triglycerides
- I have type 2 diabetes
- I have a family history of diabetes
- I have insulin resistance/Pre-diabetes
- I had or have Polycystic Ovarian Disease (PCOD)

Thank you for participating in your own health and wellbeing.

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Health Solutions to determine the appropriate health services. I also understand that all patient related information is kept strictly confidential by Health Solutions. Finally, I agree that I am financially responsible for all charges and will pay at the time services are rendered.

Signature _____ Date ____/_____/_____