PILLARS OF GI HEALTH

Patient Name: _____

Date: _____

Questionnaire

Understanding key contributors to gastrointestinal (GI) health will help identify the best course of action for recovery of GI function. After reviewing this questionnaire with your health care provider, please refer to the Pillars of GI Health Patient Handbook for dietary, lifestyle and nutrient therapy recommendations.

Please list your top 3 major health concerns in order of importance:

1. _____
2. _____
3. _____

Diet and Gastrointestinal Health

- Do you consume at least five servings of fruits and vegetables per day? Y N
- Do you drink at least eight 8 oz glasses of water every day? Y N
- Do you regularly consume soft drinks or fruit juices? Y N
- Have you ever been diagnosed with a chronic GI condition? Y N

Digestion and Absorption

- Do you experience frequent heartburn, burping, gas or bloating during or immediately after meals? Y N
- Have you ever been diagnosed with anemia or any other nutrient deficiency? Y N
- Have you ever been placed on a heartburn medication (proton pump inhibitor [PPI] or H2 blocker)? Y N
- Do you frequently experience indigestion? Y N

Elimination and Detoxification

- Do you regularly have less than one or more than three bowel movements per day? Y N
- Do you take a laxative more than twice a month? Y N
- Are you sensitive to smells or fragrances? Y N
- Do you have regular exposure to exhaust fumes, tobacco smoke, pesticides, commercial chemicals, paint, cleaning chemicals or volatile fumes? Y N

Microbial Balance

- Have you used antibiotics within the past two years? Y N
- Do you experience abdominal bloating, pain, gas, constipation or diarrhea? Y N
- Have you ever been diagnosed with chronic fatigue syndrome, fibromyalgia or irritable bowel syndrome? Y N
- Do you experience poor memory, difficulty concentrating or brain fog? Y N

Barrier Function

- Have you ever been diagnosed with depression, anxiety, ADD or ADHD? Y N
- Do you suffer from multiple food sensitivities? Y N
- Do you experience skin issues such as acne, rosacea or eczema? Y N
- Do you have seasonal allergies, asthma or an autoimmune disease? Y N