

## What caused my SIBO?



## 1. IMPAIRED MOTILITY Have you ever been diagnosed with any of the following? (PLEASE TICK RELEVANT ILLNESS/ILLNESSES) **Autoimmunity** ☐ chronic fatigue syndrome chronic viral illness Have you had a case of gastroenteritis/food ☐ lime disease fibromyalga poisoning/travellers diarrhoea lasting for YES NO longer than 24 hours? Have you been ill after a tick bite? YES NO Do you have an autoimmune condition? YES NO Are you allergic to red meat? YES NO Do you have a family history of YES NO **Mould Toxicity** autoimmunity? Are you sensitive to mould? YES NO Traumatic Brain Injury (TBI) Do you have mould in your home? YES NO Have you had an injury to the head/spine or whiplash? (PLEASE TICK RELEVANT INJURY/INJURIES) Have you ever lived in a mouldy home and YES NO have not felt will since? horse riding accident bike accident Hypermobility Disorder accident sporting injury Have you ever been diagnosed with Ehler's other (PLEASE DETAIL): Danlos Syndrome (EDS) or hypermobility YES NO syndrome? Have you ever suffered a concussion? YES NO Are you double jointed? YES NO YES NO Have you ever lost consciousness? Have you ever jarred or fallen on your YES NO 2. IMPAIRED DIGESTION coccyx/tailbone? Indicate your response to the questions below, using this **Thyroid Disorders** scale: 0 = NO 1 = MILD 2 = MODERATE 3 = SEVERE Have you ever been diagnosed with a YES NO Do you experience belching or gas within thuroid disorder? one hour after eating? Are you on thyroid medication? YES NO Do you suffer from heartburn or acid reflux? **Diabetes** Do you have bad breath? Have you ever been told you have metabolic syndrome, pre-diabetes YES NO Do you have trouble or diabetes? digesting meat? Do you experience a sense of excessive fullness aftermeals? Infections Do you experience stomach pain Do you have a history of chronic YES NO or cramping? antibiotic use? Do you often see undigested food in ☐ Childhood (FOR WHAT?) your stool?

Do your stools appear greasy or

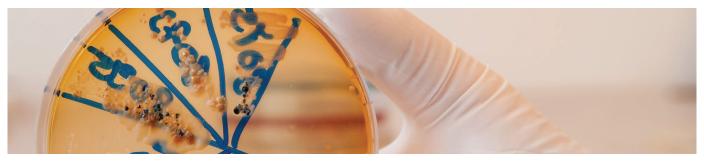
difficult to flush?

☐ Teen (FOR WHAT?)

☐ Adult (FOR WHAT?)



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2. IMPAIRED DIGESTION cont'd	Please list medications you have <b>taken in the past.</b>					
Do you, or have you, experienced ongoing high levels of stress and/or anxiety?	YES	NO				
Rate your current level of stress/anxiety from 1–10, with 1 equalling no stress/anxiety, and 10 equalling extreme stress/anxiety						
3. IMPAIRED OUTFLOW						
Do you have a history of any abdominal surge PLEASE TICK RELEVANT SURGERIES)	eries suc	h as:				
removal of appendix hernia repair						
removal of gall bladder						
other (PLEASE DETAIL)						
Do you have a history of gynaecological issues or surgeries? i.e. endometriosis, hysterectomy, caesarean, pelvic inflammatory disease, ruptured ovarian cysts, laparoscopy?	YES	NO				
Have you ever been diagnosed with any anatomical abnormalities of your digestive tract? i.e. blind loops, diverticulitis, superior mesenteric artery syndrome.	YES	NO	Do you take antidepressan	ts?	YES	NO
			IF YES, PLEASE DETAIL:			
			Do you take antispasmodic	:s?	YES	NO
			IF YES, PLEASE DETAIL:			
4. MEDICATIONS			Do you take opiates or nare	cotics?	YES	NO
Please list medications you are <b>currently taking.</b>			IF YES, PLEASE DETAIL:			
			Do you take proton pump in or antacids?	nhibitors	YES	NO
			IF YES, PLEASE DETAIL:			
			Do you take Cholestyramin	ie?	YES	NO
			Do you take antidiarrhoeal	medications?	YES	NO
			DISCLAIMER: This guide is not inten patient, please ask your medical pro			