

# What caused my SIBO?



## 1. IMPAIRED MOTILITY

### Autoimmunity

Have you had a case of gastroenteritis/food poisoning/travellers diarrhoea lasting for longer than 24 hours? **YES** **NO**

Do you have an autoimmune condition? **YES** **NO**

Do you have a family history of autoimmunity? **YES** **NO**

### Traumatic Brain Injury (TBI)

Have you had an injury to the head/spine or whiplash? (PLEASE TICK RELEVANT INJURY/INJURIES)

horse riding accident  bike accident

car accident  sporting injury

other (PLEASE DETAIL):

Have you ever suffered a concussion? **YES** **NO**

Have you ever lost consciousness? **YES** **NO**

Have you ever jarred or fallen on your coccyx/tailbone? **YES** **NO**

### Thyroid Disorders

Have you ever been diagnosed with a thyroid disorder? **YES** **NO**

Are you on thyroid medication? **YES** **NO**

### Diabetes

Have you ever been told you have metabolic syndrome, pre-diabetes or diabetes? **YES** **NO**

### Infections

Do you have a history of chronic antibiotic use? **YES** **NO**

Childhood (FOR WHAT?)

Teen (FOR WHAT?)

Adult (FOR WHAT?)

Have you ever been diagnosed with any of the following? (PLEASE TICK RELEVANT ILLNESS/ILLNESSES)

chronic fatigue syndrome  chronic viral illness

fibromyalgia  Lyme disease

Have you been ill after a tick bite? **YES** **NO**

Are you allergic to red meat? **YES** **NO**

### Mould Toxicity

Are you sensitive to mould? **YES** **NO**

Do you have mould in your home? **YES** **NO**

Have you ever lived in a mouldy home and have not felt well since? **YES** **NO**

### Hypermobility Disorder

Have you ever been diagnosed with Ehler's Danlos Syndrome (EDS) or hypermobility syndrome? **YES** **NO**

Are you double jointed? **YES** **NO**

## 2. IMPAIRED DIGESTION

Indicate your response to the questions below, using this scale: 0 = NO 1 = MILD 2 = MODERATE 3 = SEVERE

Do you experience belching or gas within one hour after eating?

Do you suffer from heartburn or acid reflux?

Do you have bad breath?

Do you have trouble digesting meat?

Do you experience a sense of excessive fullness after meals?

Do you experience stomach pain or cramping?

Do you often see undigested food in your stool?

Do your stools appear greasy or difficult to flush?

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## 2. IMPAIRED DIGESTION *cont'd*

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 surgeries such as: (PLEASE TICK RELEVANT SURGERIES)

- 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

## 4. MEDICATIONS

Please list medications you are **currently taking**.

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Please list medications you have **taken in the past**.

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Do you take antidepressants? YES NO  
 IF YES, PLEASE DETAIL:

Do you take antispasmodics? YES NO  
 IF YES, PLEASE DETAIL:

Do you take opiates or narcotics? YES NO  
 IF YES, PLEASE DETAIL:

Do you take proton pump inhibitors or antacids? YES NO  
 IF YES, PLEASE DETAIL:

Do you take Cholestyramine? YES NO

Do you take antidiarrhoeal medications? YES NO

DISCLAIMER: This guide is not intended as medical advice. If you are a patient, please ask your medical provider if these products are indicated in your case.