ANew Health

Leaky Gut Risk Evaluation

This questionnaire helps to evaluate some of the risk factors associated with Leaky Gut. Please fill take your time and fill this out as accurately as possible. Thank you.

Name _____ Date _____

1. Do you have? ___ Yes ___ No
   ___Low Energy ___ Feel Fatigued

2. Do you have any? ___ Yes ___ No
   ___ Food Intolerances ___ Food Sensitivities
   ___ Food Allergies

List Foods:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

3. Do you have any skin complaints such as? ___ Yes ___ No
   ___ Itchy Skin ___ Rashes
   ___ Eczema ___ Rosacea
   ___ Acne ___ Hives
   ___ Psoriasis ___ Other _____
   _____

4. Do you have? ___ Yes ___ No
   ___ Seasonal Allergies ___ Environmental Allergies
   ___ Pet Allergies ___ Asthma

List Allergies: _____
_____
_____

5. For your height, do you feel that you are? ___ Yes ___ No
   ___ Overweight ___ Underweight

6. Do you experience:
   ___ Joint Pain ___ Muscle Pain
   ___ Arthritis

7. Do you have digestive complaints like? ___ Yes __ No
   ___ Constipation ___ Diarrhea
   ___ Gas ___ Bloating
   ___ Burping ___ Acid Reflux
   ___ GERD ___ IBS

Please explain: _____
_____
_____

8. Do you have any brain complaints like? ___ Yes ___ No

___ Brain Fog ___ Anxiety
___ Chronic Headaches ___ Depression
___ Anxiety ___ ADHD

Please explain: _____
_____
_____

9. Have you been diagnosed with an inflammatory bowel disease like? ___ Yes ___ No

___ Crohn's disease ___ Ulcerative Colitis
___ Diverticulitis
_____ Year of Diagnosis

10. Do you have any of the following Autoimmune Diseases like? ___ Yes ___ No

___Type 1 Diabetes ___ Rheumatoid Arthritis
___ Grave's Disease ___ Celiac Disease
___ Lupus ___ Hashimoto's Thyroiditis
_____ Year of Diagnosis

11. Do you have or ever had a diagnosis of Candida Overgrowth? ___ Yes ___ No

___Current Diagnosis ___ Past Diagnosis
_____ Year of Diagnosis

12. Do you have a diagnosis of? ___ Yes ___No

___ CFIDS ___ Fibromylagia
_____ Year of Diagnosis

13. Do you have a diagnosis of Hypothyroidism or Hashimoto's Thyroiditis? ___ Yes ___ No

___ Hypothyroidism since _____ Year ___ Hashimoto's since _____Year

Explain treatment you are receiving for this: _____
_____

14. Do you have a diagnosis of or ever had a diagnosis of? ___ Yes ___ No

___ SIBO ___ Bacterial Infection in Gut
_____Year of Diagnosis ___ Parasites: If Yes, please put name of parasites below.

Explain treatment for this: _____
_____

15. Do you take on a regular basis, used to take frequently, or took for a long time? ___ Yes ___ No

___ Proton Pump Inhibitor (ie: Nexium, Prilosec, etc))
___ Non Steroidal Anti-inflammatory OTC (ie: Motrin, Aleve, Advil)
___ Steroids Orally or Injections
___ Antibiotics

If yes to any, please indicate if currently taking, took in the past, and how many years.

___ Currently taking _____ medication for _____ years
___ Currently taking _____ medication for _____ years
___ Used to take _____ medication for _____ years
___ Used to take _____ medication for _____ years

Comments: _____
_____

16. Is your regular intake of food high in:

___ Sugar ___ Alcohol

___ Gluten (found in wheat, rye, pastries, pasta, bread, etc)

If Yes to any, please explain. _____

_____

_____

_____

17. What is your NUMBER ONE HEALTH COMPLAINT?

___ Weight ___ My Hormones

___ Energy Levels ___ My Autoimmunity

___ Digestive Problems ___ Depression/Anxiety

___ Skin Problems ___ Other _____

18. What is your NUMBER TWO HEALTH COMPLAINT?

___ Weight ___ My Hormones

___ Energy Levels ___ My Autoimmunity

___ Digestive Problems ___ Depression/Anxiety

___ Skin Problems ___ Other _____

19. What is your NUMBER THREE HEALTH COMPLAINT?

___ Weight ___ My Hormones

___ Energy Levels ___ My Autoimmunity

___ Digestive Problems ___ Depression/Anxiety

___ Skin Problems ___ Other _____