

# 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)

<input type="checkbox"/> horse riding accident	<input type="checkbox"/> bike accident	
<input type="checkbox"/> car accident	<input type="checkbox"/> sporting injury	
<input type="checkbox"/> 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
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### Infections

Do you have a history of chronic antibiotic use?	YES	NO
<input type="checkbox"/> Childhood (FOR WHAT?)		
<input type="checkbox"/> Teen (FOR WHAT?)		
<input type="checkbox"/> Adult (FOR WHAT?)		

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

<input type="checkbox"/> chronic fatigue syndrome	<input type="checkbox"/> chronic viral illness	
<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> 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

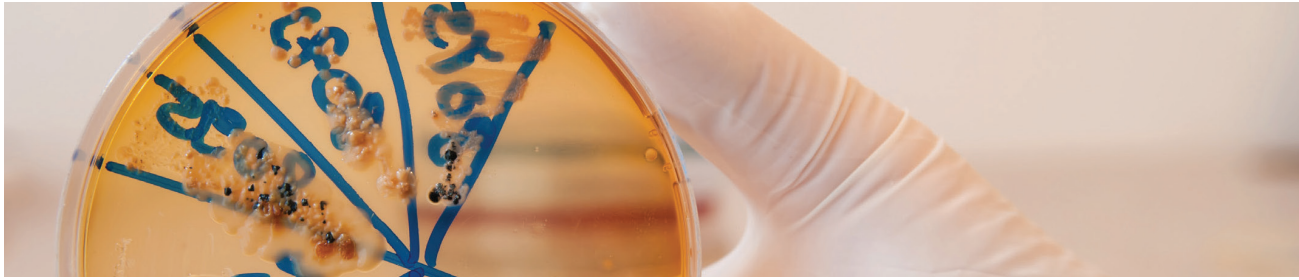
Have you ever been diagnosed with Ehler's Danlos Syndrome (EDS) or hypermobility syndrome?	YES	NO
Are you double jointed?	YES	NO

## 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?	<input type="text"/>
Do you suffer from heartburn or acid reflux?	<input type="text"/>
Do you have bad breath?	<input type="text"/>
Do you have trouble digesting meat?	<input type="text"/>
Do you experience a sense of excessive fullness after meals?	<input type="text"/>
Do you experience stomach pain or cramping?	<input type="text"/>
Do you often see undigested food in your stool?	<input type="text"/>
Do your stools appear greasy or difficult to flush?	<input type="text"/>

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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.