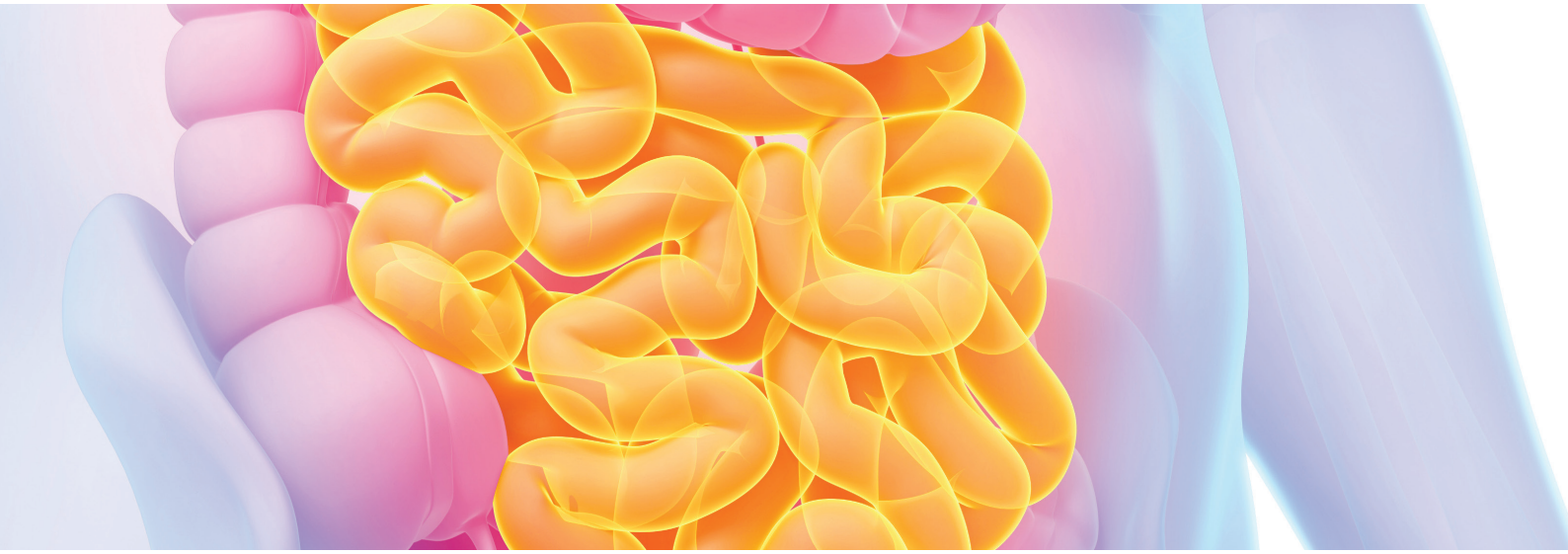
What Caused My SIBO?



IMPAIRED MOTILITY

Autoimmunity

1. You had a case of gastroenteritis/food poisoning/travellers diarrhoea lasting for longer than 24 hours? YES / NO
2. Do you have an autoimmune condition? YES / NO
3. Do you have a family history of autoimmunity? YES / NO

Traumatic Brain Injury (TBI)

4. Have you had an injury to the head/spine or whiplash? (Please circle)
   Horse-riding accident Bike accident Car accident Sporting injury Other
5. Have you ever suffered a concussion? YES / NO
6. Have you ever lost consciousness? YES / NO
7. Have you ever jarred or fallen on your coccyx/tailbone? YES / NO

Thyroid

8. Have you ever been diagnosed with a thyroid disorder? YES / NO
9. Are you on thyroid medication? YES / NO

Diabetes

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

Chronic Infections

11. Do you have a history of chronic antibiotic use? YES / NO
    - Childhood – what for? _____
    - Teen – what for? _____
    - Adult – what for? _____

Stealth Infections

12. Have you ever been diagnosed with (Please circle)
    Chronic Fatigue Syndrome Fibromyalgia Chronic viral illness Lyme Disease?
13. Have you been ill after a tick bite? YES / NO
14. Are you allergic to red meat? YES / NO

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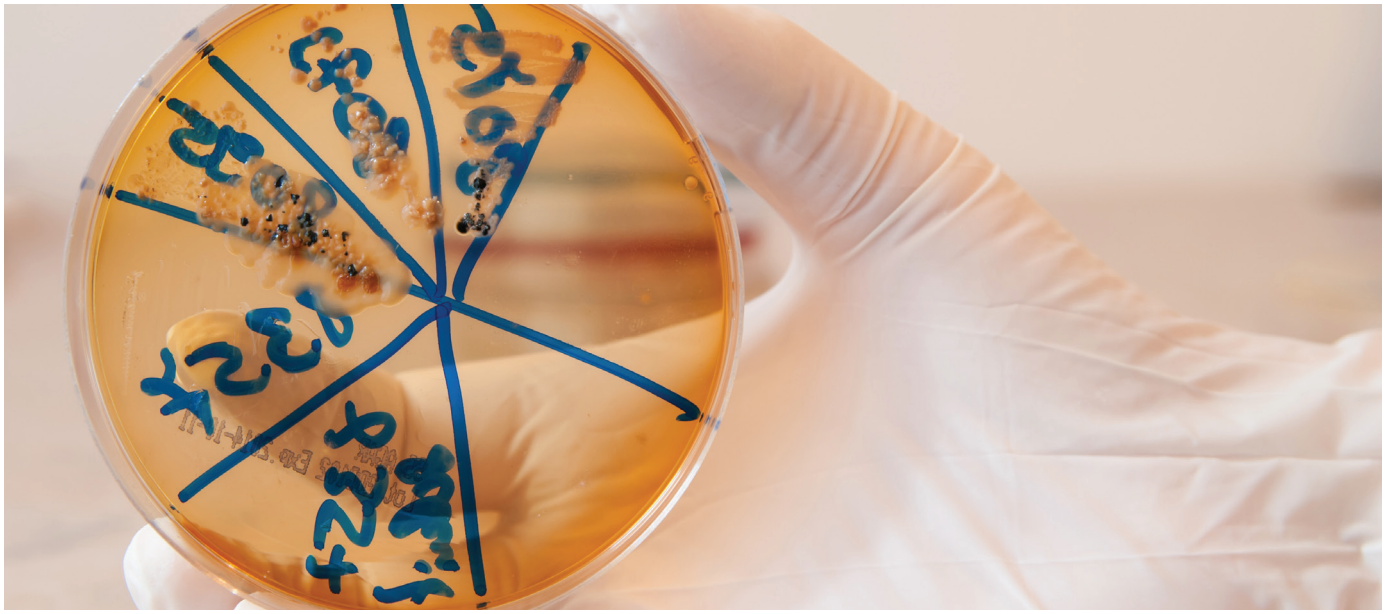

Mould Toxicity

1. Are you sensitive to mould? YES / NO
2. Do you have mould in your home? YES / NO
3. Have you ever lived in a mouldy home and have not felt well since? YES / NO

Ehlers Danlos Syndrome (EDS)

1. Have you ever been diagnosed with EDS or other hypermobility syndrome? YES / NO
2. Are you double-jointed? YES / NO

Impaired Digestion

0=No 1=mild 2=moderate 3=severe (please circle)

3. Do you experience belching or gas within one hour after eating? 0 1 2 3
4. Do you suffer from heartburn or acid reflux? 0 1 2 3
5. Do you have bad breath? 0 1 2 3
6. Do you have trouble digesting meat? 0 1 2 3
7. Do you experience a sense of excessive fullness after meals? 0 1 2 3
8. Do you experience stomach pain or cramping? 0 1 2 3
9. Do you often see undigested food in your stool? 0 1 2 3
10. Do your stools appear greasy or difficult to flush? 0 1 2 3

Impaired Outflow

Abdominal surgeries

11. Do you have a history of any abdominal surgeries such as (please circle)
    Removal of appendix Gall bladder Hernia repair
12. Do you have a history of gynaecological issues or surgeries ie: endometriosis, hysterectomy, caesarean, pelvic inflammatory disease, ruptured ovarian cysts, laparoscopy? YES / NO
13. Have you ever been diagnosed with any anatomical abnormalities of your digestive tract? (blind loops, diverticulitis, superior mesenteric artery syndrome) YES /NO

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MEDICATIONS

14. Medications you currently take:
    List:

15. Medications you have taken in the past:
    List:

16. Antidepressants Y/N
    What type:

17. Antispasmodics Y/N
    What type:

18. Opiates or Narcotics Y/N
    What type:

19. Proton pump inhibitors or antacids Y/N
    What type:

20. Cholestyramine YES /NO

21. Antidiarrhoeal medications YES/ NO

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

1. Tingling and/or numbness of your hands and/or feet YES/NO
2. Intolerance to light and/or noise YES/NO
3. Bladder irritation/burning urination (Interstitial Cystitis) YES/NO
4. Body ache/body pain (Fibromyalgia) YES/NO
5. Odorous gas (Sulfur odor - rotten egg odor) YES/NO