Gut Health Questionnaire

Section 1: Digestive Symptoms

1. Do you experience bloating?

- Never
- Occasionally
- Frequently
- Every day

2. Do you experience gas?

- Rarely / not bothersome
- Occasionally, mild
- Frequently, foul-smelling

3. How often do you have a bowel movement?

- More than once daily
- Once daily

- Every 2–3 days
- Less than 3 times per week

4. Do you experience…? (tick all that apply)

- Constipation
- Diarrhea
- Undigested food in stool
- Mucus in stool
- Blood in stool
- Oily residue
- None of the above

5. Do you have reflux, heartburn, or indigestion?

- Yes
- No

Section 2: Food Triggers & Eating Habits

6. Do you notice symptoms after consuming the following? (tick all that apply)

- Gluten
- Dairy
- Sugar
- Processed foods
- Alcohol

- None of the above

7. Do you experience strong food cravings?

- Sugar
- Carbohydrates
- Salt
- Caffeine
- None

8. How often do you skip meals or eat on the go?

- Rarely
- Sometimes
- Often

Section 3: Microbiome & Immune History

9. Were you born via C-section or vaginal delivery?

- Vaginal delivery
- C-section
- Not sure

10. Were you breastfed as an infant?

- Yes
- No
- Not sure

11. Have you used antibiotics frequently (as a child or adult)?

- Yes
- No

12. Do you suffer from any of the following? (tick all that apply)

- Allergies
- Asthma
- Eczema or skin conditions
- Autoimmune conditions
- None of the above

Section 4: Lifestyle & Stress

13. How would you rate your current stress level?

- Low
- Moderate
- High

14. Do you experience mood issues? (tick all that apply)

- Anxiety
- Depression
- Mood swings
- Brain fog

15. On average, how many hours of sleep do you get per night?

- Less than 5
- 5–6
- 7–8

Section 5: Environmental & Toxin Exposure

16. Do you usually drink…

- Tap water
- Filtered water
- Bottled water

17. Do you have exposure to any of the following? (tick all that apply)

- Pesticides or chemicals
- Mold
- Artificial sweeteners
- Frequent medication use (NSAIDs, antacids, steroids)
- None

Section 6: Overall Health

18. Do you experience any of the following? (tick all that apply)

- Skin issues (acne, eczema, psoriasis)

- Joint pain or stiffness
- Fatigue or low energy
- Weight gain/difficulty losing weight
- Nutrient deficiencies (iron, B12, vitamin D, magnesium, etc.)
- None

Section 7: Stool & Digestion

19. Which stool type best matches your usual bowel movements?
(Insert Bristol Stool Chart image in Google Forms for reference)

- Type 1 (separate hard lumps)
- Type 2 (sausage-shaped but lumpy)
- Type 3 (like a sausage with cracks)
- Type 4 (smooth and soft, like a snake)
- Type 5 (soft blobs with clear edges)
- Type 6 (fluffy pieces, mushy stool)
- Type 7 (watery, no solid pieces)

20. Do your bowel movements feel complete and easy to pass?

- Yes
- No

Section 8: Female-Specific (optional)

21. Do your gut symptoms worsen around your menstrual cycle?

- Yes
- No

22. Have you been diagnosed with any of the following? (tick all that apply)

- PMS
- PCOS
- Endometriosis
- None

23. Have you used birth control pills or hormone therapy long-term?

- Yes
- No

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