

SELF-CHECK QUESTIONNAIRE

NAME

DAY 1

Rate your symptoms on a scale of 10 (extreme) down to 1 (minimal).
Place your score in the right hand column and add up your total.

DATE / /

| SYMPTOM | SCALE | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | SCORE | |
|--------------------------|-------------------|----|---|---|---|---|---|---|---|---|---|------------------|--|
| | | | | | | | | | | | | | |
| TIRED | Extremely | | | | | | | | | | | Never | |
| TEMPERAMENT | Racy | | | | | | | | | | | Calm | |
| A LITTLE SNAPPY | Very Bad Tempered | | | | | | | | | | | Placid | |
| A LITTLE EMOTIONAL | Highly | | | | | | | | | | | Balanced | |
| FOOD DOESN'T DIGEST | Uncomfortable | | | | | | | | | | | No Problem | |
| SHORT TERM MEMORY | Forget Easily | | | | | | | | | | | Great Memory | |
| SUGAR CRAVINGS | Love Sweets | | | | | | | | | | | Don't Need Sugar | |
| LIBIDO | Very Low | | | | | | | | | | | High | |
| COLD HANDS OR FEET | Very Cold | | | | | | | | | | | Normal | |
| FEELING OF HOPELESSNESS | Depressed | | | | | | | | | | | Life is Good | |
| MIGRAINES | Extreme | | | | | | | | | | | No Headaches | |
| THRUSH | Frequently | | | | | | | | | | | Never | |
| BOWEL MOVEMENTS | Irregular | | | | | | | | | | | Frequent/Normal | |
| CONSTIPATION | 10 Days Apart | | | | | | | | | | | Every Day | |
| WEIGHT | Need to Lose | | | | | | | | | | | Slim | |
| APPETITE | Always Snacking | | | | | | | | | | | Never Hungry | |
| ACNE | Extreme | | | | | | | | | | | Nil | |
| VOICE | Very Deep | | | | | | | | | | | Soft | |
| HIGHLY STRUNG | Volatile | | | | | | | | | | | Calm | |
| IRRITABLE BOWEL SYNDROME | Bad | | | | | | | | | | | No | |
| SLEEP PATTERNS | Poor | | | | | | | | | | | Very Good | |
| NUMBER OF HOURS OF SLEEP | 10 or More | | | | | | | | | | | 5 to 8 | |
| RESTLESS LEGS | Often | | | | | | | | | | | Never | |
| LOWER BACK PAIN | Extreme | | | | | | | | | | | Never | |
| WIND / BLOATING | Often | | | | | | | | | | | Never | |
| YOUR PERSONAL CONDITION | | | | | | | | | | | | | |
| | Extreme | | | | | | | | | | | Minimal | |
| OTHER | | | | | | | | | | | | | |
| | Extreme | | | | | | | | | | | Minimal | |

SUPPORT
Phone Mon to Fri (07) 554 66 086
Email info@probioticfoods.com.au

CURRENT
WEIGHT

SCORE
TOTAL



DAY 30

Rate your symptoms on a scale of 10 (extreme) down to 1 (minimal).
Place your score in the right hand column and add up your total.

DATE / /

| SYMPTOM | SCALE | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | SCORE | |
|--------------------------|-------------------|----|---|---|---|---|---|---|---|---|---|------------------|--|
| | | | | | | | | | | | | | |
| TIRED | Extremely | | | | | | | | | | | Never | |
| TEMPERAMENT | Racy | | | | | | | | | | | Calm | |
| A LITTLE SNAPPY | Very Bad Tempered | | | | | | | | | | | Placid | |
| A LITTLE EMOTIONAL | Highly | | | | | | | | | | | Balanced | |
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| SHORT TERM MEMORY | Forget Easily | | | | | | | | | | | Great Memory | |
| SUGAR CRAVINGS | Love Sweets | | | | | | | | | | | Don't Need Sugar | |
| LIBIDO | Very Low | | | | | | | | | | | High | |
| COLD HANDS OR FEET | Very Cold | | | | | | | | | | | Normal | |
| FEELING OF HOPELESSNESS | Depressed | | | | | | | | | | | Life is Good | |
| MIGRAINES | Extreme | | | | | | | | | | | No Headaches | |
| THRUSH | Frequently | | | | | | | | | | | Never | |
| BOWEL MOVEMENTS | Irregular | | | | | | | | | | | Frequent/Normal | |
| CONSTIPATION | 10 Days Apart | | | | | | | | | | | Every Day | |
| WEIGHT | Need to Lose | | | | | | | | | | | Slim | |
| APPETITE | Always Snacking | | | | | | | | | | | Never Hungry | |
| ACNE | Extreme | | | | | | | | | | | Nil | |
| VOICE | Very Deep | | | | | | | | | | | Soft | |
| HIGHLY STRUNG | Volatile | | | | | | | | | | | Calm | |
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| YOUR PERSONAL CONDITION | | | | | | | | | | | | | |
| | Extreme | | | | | | | | | | | Minimal | |
| OTHER | | | | | | | | | | | | | |
| | Extreme | | | | | | | | | | | Minimal | |

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CURRENT WEIGHT

SCORE TOTAL

