Heal Leaky Gut

Rapidly improve your entire digestive system to ensure you are the healthiest you have ever been.

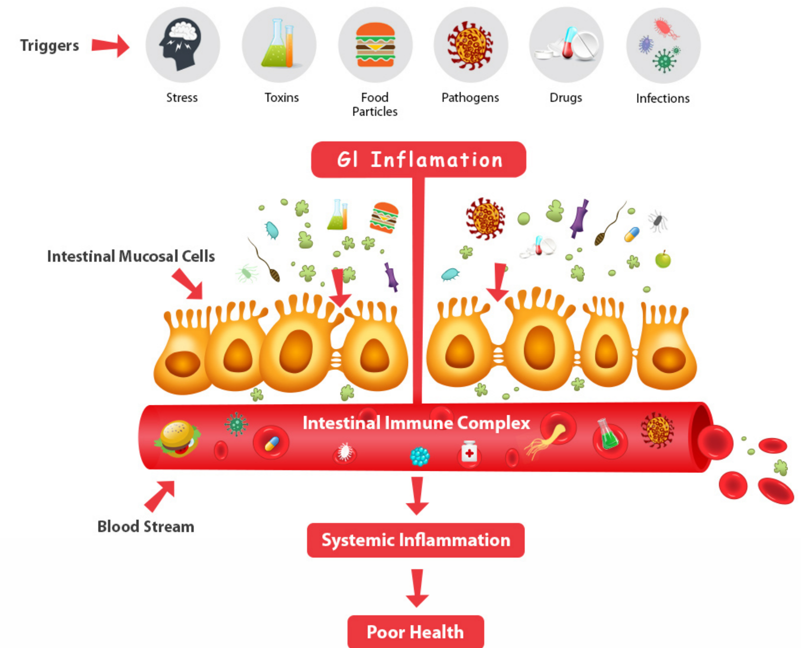
Pre-Assessment and Post Assessment Questionnaire
Symptoms Journal
Blank Meal Plan Charts

LEAKY GUT

INTRODUCTION

Leaky gut is a term used as a descriptor for increased intestinal permeability. Imagine your intestines as a long hose. If the hose is not damaged, then water will move freely through one end and out the other side. Now, imagine that same hose with tiny punctures. The water now leaks out before reaching its intended destination. Leaky Gut Syndrome is similar to a damaged hose, as particles can leak out into the body where they shouldn't be. This causes damage and dysfunction resulting in poor health.

Your intestines are designed to act as a natural and selective barrier allowing nutrients in while keeping foreign objects from entering and reaching the blood supply. With leaky gut, there is damage to this natural barrier, exposing our body's immune system to objects it normally isn't exposed to.   A healthy functioning intestinal mucosa is the body's primary line of defense against these potentially lethal agents. Let's start building a healthy functioning intestinal barrier!



BEFORE PROGRAM ASSESSMENT

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PROGRAM ASSESSMENT #1

BEFORE STARTING PROGRAM QUESTIONNAIRE

How often in the last 30 days did you experience the following:

Circle the most relevant number for each reaction.

SYMPTOMS	NOT BOTHERSOME		SOMEWHAT BOTHERSOME		EXTREMELY BOTHERSOME		
Abdominal discomfort, pain, or cramps	0	1	2	3	4	5	6
Hard or lumpy stools	0	1	2	3	4	5	6
Loose or watery stools	0	1	2	3	4	5	6
Straining during a bowel movement	0	1	2	3	4	5	6
Urgency - having to rush to the toilet	0	1	2	3	4	5	6
Feeling incomplete bowel movement	0	1	2	3	4	5	6
Passing mucus (white material) during a bowel movement	0	1	2	3	4	5	6
Abdominal fullness, bloating, or swelling	0	1	2	3	4	5	6
Passing gas	0	1	2	3	4	5	6
Heartburn or chest pain	0	1	2	3	4	5	6
Feeling full soon after starting a meal	0	1	2	3	4	5	6
Passing urine more frequently	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6

PROGRAM ASSESSMENT #1

Rate each of the following symptoms based upon your typical health profile for:

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD

Symptom					
Headaches	0	1	2	3	4
Faintness	0	1	2	3	4
Dizziness	0	1	2	3	4
Insomnia	0	1	2	3	4

EYES

Symptom					
Watery or itchy eyes	0	1	2	3	4
Swollen, reddened or sticky eyelids	0	1	2	3	4
Bags or dark circles under eyes	0	1	2	3	4
Blurred or tunnel vision	0	1	2	3	4

MOUTH / THROAT

Symptom					
Chronic coughing	0	1	2	3	4
Gagging, frequent need to clear throat	0	1	2	3	4
Sore throat, hoarseness, loss of voice	0	1	2	3	4
Swollen or discolored tongue, gums, lips	0	1	2	3	4
Canker sores	0	1	2	3	4

NOSE

Symptom					
Stuffy nose	0	1	2	3	4
Sinus problems	0	1	2	3	4
Hay fever	0	1	2	3	4
Sneezing attacks	0	1	2	3	4
Excessive mucus	0	1	2	3	4

EARS

Symptom					
Itchy ears	0	1	2	3	4
Earaches, ear infections	0	1	2	3	4
Drainage from ear	0	1	2	3	4
Ringing in ears, hearing loss	0	1	2	3	4

PROGRAM ASSESSMENT #1

SKIN

Symptom					
Acne	0	1	2	3	4
Hives, rashes, dry skin	0	1	2	3	4
Hair loss	0	1	2	3	4
Flushing, hot flushes	0	1	2	3	4
Excessive sweating	0	1	2	3	4

HEART

Symptom					
Irregular or skipped heartbeat	0	1	2	3	4
Rapid or pounding heartbeat	0	1	2	3	4
Chest pain	0	1	2	3	4

WEIGHT

Symptom					
Binge eating or drinking	0	1	2	3	4
Craving certain foods	0	1	2	3	4
Excessive weight	0	1	2	3	4
Compulsive eating	0	1	2	3	4
Water retention	0	1	2	3	4
Underweight	0	1	2	3	4

JOINT & MUSCLES

Symptom					
Pain or aches in joints	0	1	2	3	4
Arthritis	0	1	2	3	4
Stiffness or limitation of movement	0	1	2	3	4
Pain or aches in muscles	0	1	2	3	4
Feeling of weakness or tiredness	0	1	2	3	4

LUNGS

Symptom					
Chest congestion	0	1	2	3	4
Asthma, bronchitis	0	1	2	3	4
Shortness of breath	0	1	2	3	4
Difficulty breathing	0	1	2	3	4

ENERGY / ACTIVITY

Symptom					
Fatigue, sluggishness	0	1	2	3	4
Hyperactivity	0	1	2	3	4
Apathy, lethargy	0	1	2	3	4
Restlessness	0	1	2	3	4

PROGRAM ASSESSMENT #1

EMOTIONS

Symptom					
Mood swings	0	1	2	3	4
Anxiety, fear, nervousness	0	1	2	3	4
Anger, irritability, aggressiveness	0	1	2	3	4
Depression	0	1	2	3	4

MIND

Symptom					
Poor memory	0	1	2	3	4
Confusion, poor comprehension	0	1	2	3	4
Poor concentration	0	1	2	3	4
Poor physical coordination	0	1	2	3	4
Difficulty in making decisions	0	1	2	3	4
Stuttering, stammering	0	1	2	3	4
Slurred speech	0	1	2	3	4
Learning disabilities	0	1	2	3	4

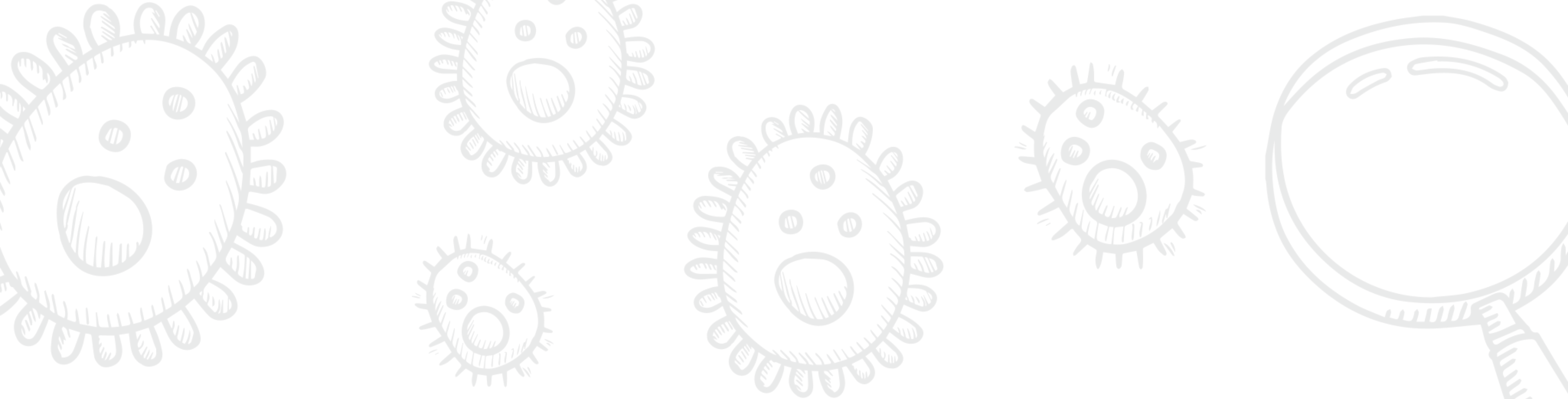
DIGESTIVE

Symptom					
Nausea and/or vomiting	0	1	2	3	4
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Bloated feeling	0	1	2	3	4
Blenching and/or passing gas	0	1	2	3	4
Heartburn	0	1	2	3	4
Intestinal/stomach pain	0	1	2	3	4

OTHER

Symptom					
Frequent illness	0	1	2	3	4
Frequent or urgent urination	0	1	2	3	4
Genital itch or discharge	0	1	2	3	4

TOTAL



AFTER PROGRAM ASSESSMENT

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1 MONTH AFTER COMPLETION OF PROGRAM QUESTIONNAIRE

How often in the last 30 days did you experience the following:

Circle the most relevant number for each reaction.

SYMPTOMS	NOT BOTHERSOME		SOMEWHAT BOTHERSOME		EXTREMELY BOTHERSOME		
Abdominal discomfort, pain, or cramps	0	1	2	3	4	5	6
Hard or lumpy stools	0	1	2	3	4	5	6
Loose or watery stools	0	1	2	3	4	5	6
Straining during a bowel movement	0	1	2	3	4	5	6
Urgency -having to rush to the toilet	0	1	2	3	4	5	6
Feeling incomplete bowel movement	0	1	2	3	4	5	6
Passing mucus (white material) during a bowel movement	0	1	2	3	4	5	6
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Passing gas	0	1	2	3	4	5	6
Heartburn or chest pain	0	1	2	3	4	5	6
Feeling full soon after starting a meal	0	1	2	3	4	5	6
Passing urine more frequently	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6

MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for:

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD

Symptom					
Headaches	0	1	2	3	4
Faintness	0	1	2	3	4
Dizziness	0	1	2	3	4
Insomnia	0	1	2	3	4

EYES

Symptom					
Watery or itchy eyes	0	1	2	3	4
Swollen, reddened or sticky eyelids	0	1	2	3	4
Bags or dark circles under eyes	0	1	2	3	4
Blurred or tunnel vision	0	1	2	3	4

MOUTH / THROAT

Symptom					
Chronic coughing	0	1	2	3	4
Gagging, frequent need to clear throat	0	1	2	3	4
Sore throat, hoarseness, loss of voice	0	1	2	3	4
Swollen or discolored tongue, gums, lips	0	1	2	3	4
Canker sores	0	1	2	3	4

NOSE

Symptom					
Stuffy nose	0	1	2	3	4
Sinus problems	0	1	2	3	4
Hay fever	0	1	2	3	4
Sneezing attacks	0	1	2	3	4
Excessive mucus	0	1	2	3	4

EARS

Symptom					
Itchy ears	0	1	2	3	4
Earaches, ear infections	0	1	2	3	4
Drainage from ear	0	1	2	3	4
Ringing in ears, hearing loss	0	1	2	3	4

SKIN

Symptom					
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Hair loss	0	1	2	3	4
Flushing, hot flushes	0	1	2	3	4
Excessive sweating	0	1	2	3	4

HEART

Symptom					
Irregular or skipped heartbeat	0	1	2	3	4
Rapid or pounding heartbeat	0	1	2	3	4
Chest pain	0	1	2	3	4

WEIGHT

Symptom					
Binge eating or drinking	0	1	2	3	4
Craving certain foods	0	1	2	3	4
Excessive weight	0	1	2	3	4
Compulsive eating	0	1	2	3	4
Water retention	0	1	2	3	4
Underweight	0	1	2	3	4

JOINT & MUSCLES

Symptom					
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Arthritis	0	1	2	3	4
Stiffness or limitation of movement	0	1	2	3	4
Pain or aches in muscles	0	1	2	3	4
Feeling of weakness or tiredness	0	1	2	3	4

LUNGS

Symptom					
Chest congestion	0	1	2	3	4
Asthma, bronchitis	0	1	2	3	4
Shortness of breath	0	1	2	3	4
Difficulty breathing	0	1	2	3	4

ENERGY / ACTIVITY

Symptom					
Fatigue, sluggishness	0	1	2	3	4
Hyperactivity	0	1	2	3	4
Apathy, lethargy	0	1	2	3	4
Restlessness	0	1	2	3	4

EMOTIONS

Symptom					
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Anxiety, fear, nervousness	0	1	2	3	4
Anger, irritability, aggressiveness	0	1	2	3	4
Depression	0	1	2	3	4

MIND

Symptom					
Poor memory	0	1	2	3	4
Confusion, poor comprehension	0	1	2	3	4
Poor concentration	0	1	2	3	4
Poor physical coordination	0	1	2	3	4
Difficulty in making decisions	0	1	2	3	4
Stuttering, stammering	0	1	2	3	4
Slurred speech	0	1	2	3	4
Learning disabilities	0	1	2	3	4

DIGESTIVE

Symptom					
Nausea and/or vomiting	0	1	2	3	4
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Bloated feeling	0	1	2	3	4
Blenching and/or passing gas	0	1	2	3	4
Heartburn	0	1	2	3	4
Intestinal/stomach pain	0	1	2	3	4

OTHER

Symptom					
Frequent illness	0	1	2	3	4
Frequent or urgent urination	0	1	2	3	4
Genital itch or discharge	0	1	2	3	4

TOTAL

ACTION PLAN

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ACTION PLAN

The elimination diet is a short-term eating plan designed to identify and eliminate specific foods that may be causing adverse reactions or symptoms in an individual. By removing certain foods from the diet and gradually reintroducing them, this approach aims to pinpoint any potential food sensitivities or allergies. The elimination diet serves as a valuable tool for understanding how different foods affect our bodies, promoting overall health and well-being.

1. Food allergy: an immediate food reaction that will always provide an immune response within minutes. The perfect example is a nut allergy, & this will always remain with the person.

2. Food sensitivity: a delayed reaction to foods which can take up to a couple days before symptoms are felt. Typical symptoms are diarrhea, bloating, skin issues, constipation, and tiredness.

3. Food intolerances: Food intolerance refers to the inability or difficulty in digesting certain foods, leading to various adverse symptoms such as bloating, stomach pain, or diarrhea, without involving the immune system. An example is lactose intolerance.

It is important to find the foods causing these issues and remove them. For some people a general clean up of the diet works just fine, for others a stricter approach is needed.

ENTER THE ELIMINATION DIET

A good elimination diet is a strict, controlled eating plan that removes the most common food sensitivities.

There are a number of ways you can start to apply elimination, and one of the easiest places to start is to simply remove the common offenders.

- Gluten (wheat)
- Dairy
- Soy
- Corn
- Eggs
- Shellfish

Please review the guidebook for a comprehensive schedule and food list.

It can also be helpful to ask a few key questions:-

- **What foods do you eat most often?**
- **What foods do you crave?**
- **What foods do you eat to feel better?**
- **What foods do you have trouble giving up?**

In order for this program to work successfully, it is important to give it sufficient time in order to help heal the GI system. This is usually around 12 weeks, depending on the severity of the problem. Again, it is important to avoid any foods that you know or believe may cause problems, even if they are on the 'allowed' list.

RE-INTRODUCTION

Once symptoms have improved it is time to start 'challenging' the body with the eliminated foods.

Start with a small amount of the food in the morning, such as a teaspoon of milk or a small piece of cheese, and consume it on an empty stomach. If you don't notice any symptoms after 24 hours, then eat two larger portions the next day. Monitor symptoms and/or triggers for 48 hours.

Wait the full 48 hours before introducing another food. This allows you time to determine if the symptoms you experienced were due to the food you reintroduced or something else.

Day 1: Introduce small amount of food

Day 2: Introduce 2 larger portions of same food category

Day 4: If no symptoms, start with a new food category.

If a food doesn't cause symptoms during the challenge, it is unlikely to be a problem food and can be introduced back into the diet.

WEEK 1 FOOD DIARY CHART

Log in foods eaten and times. Note the symptoms you experience and at what times.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
MORNING FOODS							
MORNING SYMPTOMS							
AFTERNOON FOODS							
AFTERNOON SYMPTOMS							
EVENING FOODS							
EVENING SYMPTOMS							

WEEK 2 FOOD DIARY CHART

Log in foods eaten and times. Note the symptoms you experience and at what times.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
MORNING FOODS							
MORNING SYMPTOMS							
AFTERNOON FOODS							
AFTERNOON SYMPTOMS							
EVENING FOODS							
EVENING SYMPTOMS							

WEEK 3 FOOD DIARY CHART

Log in foods eaten and times. Note the symptoms you experience and at what times.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
MORNING FOODS							
MORNING SYMPTOMS							
AFTERNOON FOODS							
AFTERNOON SYMPTOMS							
EVENING FOODS							
EVENING SYMPTOMS							

WEEK 4 FOOD DIARY CHART

Log in foods eaten and times. Note the symptoms you experience and at what times.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
MORNING FOODS							
MORNING SYMPTOMS							
AFTERNOON FOODS							
AFTERNOON SYMPTOMS							
EVENING FOODS							
EVENING SYMPTOMS							

MEAL PLAN TEMPLATE

MEAL	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
BREAKFAST							
SNACK							
LUNCH							
SNACK							
DINNER							

MEAL PLAN TEMPLATE

MEAL	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
BREAKFAST							
SNACK							
LUNCH							
SNACK							
DINNER							

MEAL PLAN TEMPLATE

MEAL	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
BREAKFAST							
SNACK							
LUNCH							
SNACK							
DINNER							

MEAL PLAN TEMPLATE

MEAL	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
BREAKFAST							
SNACK							
LUNCH							
SNACK							
DINNER							