GAPS Nutrition Analysis: Adult

DATE: / /

PERSONAL DETAILS

Please legibly print the following nutrition information

Full Name: ____ Preferred: ______________________

Age: ______ DOB: / / Female ☐ Male ☐ Weight: _____kg Height: ______ cm

Postal Address: ____ State:_______ Postcode:________

YOUR HOME LAND LINE PHONE NUMBER IS REQUIRED FOR PHONE CONSULTATIONS

Home Phone: ________________________________ Mobile Phone: _____________________________

Referring Practitioner: ______________________________

PRIMARY CONCERNS *(You may add additional information on a separate attached sheet if you like)*

Please indicate the following with a tick

Is the GAPS Program:

☐ New to you or
☐ You have you been doing the GAPS Program for ______________ (weeks/months)

Please provide your main 3 reasons (listed by priority) for coming to the GAPS Program and briefly describe your most troubling symptoms and health concerns.

1
2
3

Have you received a clinical diagnosis? comment: ____

Please list any treatment interventions you have tried previously for this condition and briefly discuss the outcome:

HALTH HISTORY

Please indicate the following with a tick

☐ Received several antibiotic treatments over time for reoccurring infections. (examples, ear infections, chest infections, thrush etc). List infections:____

☐ Were you breast fed: If so, how long for? ___________________________

☐ Vaccinations (including flu shots): Please comment: ____

☐ At what age did the onset of your symptoms or condition emerge? ___________________________________

HALTH HISTORY *continued*

GUT AND PSYCHOLOGY SYNDROME CONDITIONS:
Please indicate whether you have ever been diagnosed with any of the following or whether you suspect a problem. You may underline in a red pen for any conditions below that relate to your family members.

- ☐ Autism Spectrum Disorder
- ☐ Asperger's Syndrome
- ☐ Attention Deficit Disorder
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Dyspraxia
- ☐ Dyslexia
- ☐ Eating Disorder
- ☐ Oppositional Defiance Disorder
- ☐ Anxiety Disorder
- ☐ Panic Disorder
- ☐ Tourtte Syndrome
- ☐ Conduct Disorder

☐ Other psychological disorders:______________________________

GUT AND PHYSIOLOGY SYNDROME CONDITIONS:
Please indicate whether you relate to any of the following.

- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Pyrroles Disorder
- ☐ Antibiotic Associated Diarrhoea
- ☐ Eczema/Dermatitis
- ☐ Asthma
- ☐ Psoriasis
- ☐ Epilepsy
- ☐ Type 1 Diabetes
- ☐ GERD (Reflux)
- ☐ Multiple Sclerosis
- ☐ Hashimotos Thyroiditis
- ☐ Crohn's Disease
- ☐ Celiac
- ☐ Ulcerative Colitis
- ☐ IBS

Other Physiological conditions:______________________________

GAPS RELATED HEALTH & BEHAVIOUR ISSUES:
Please indicate whether you relate to any of the following.

- ☐ Gut Dysbiosis
- ☐ Dark circles under eyes
- ☐ Pale skin complexion
- ☐ Muscle & joint pain
- ☐ Poor sleep patterns
- ☐ Antibiotic Associated Diarrhoea
- ☐ Ear infections
- ☐ Chest infections
- ☐ Throat infection/strep
- ☐ Head Sweats
- ☐ Irritable
- ☐ Food Allergies Sensitivities
- ☐ Hay fever
- ☐ Poor memory
- ☐ Lethargy
- ☐ Migraine Headaches
- ☐ Self harms
- ☐ Nasal Drip
- ☐ Learning problems
- ☐ Mind Fog
- ☐ Low immunity
- ☐ Difficult to focus
- ☐ Aggressive to others
- ☐ Anemia/iron deficient

Other symptoms & conditions:______________________________

STOOLS / URINARY TRACT / STOMACH ACID PRODUCTION
Please respond to the following by circling the appropriate number
0 = Never or NA **1** = Occasionally **2** = Frequently **3** = Most of the time or Always

STOOLS

Alternate between diarrhea and constipation	0	1	2	3
Diarrhoea	0	1	2	3
Constipation	0	1	2	3
Experience pain when moving bowels	0	1	2	3
Avoids going to the toilet – holds on	0	1	2	3
Hard round stomach/abdomen	0	1	2	3
Stools tend to float	0	1	2	3
Flatulence	0	1	2	3
Undigested food is visible in stools	0	1	2	3
Mucus in stools	0	1	2	3
Stools look green	0	1	2	3
Stools look pasty yellow	0	1	2	3
Constant abdomen pain/cramps	0	1	2	3
Stools present as small round dark pebbles	0	1	2	3

URINARY TRACT

Bed wetting	0	1	2	3
Constant urgency or need to urinate	0	1	2	3
Thrush (Yeast overgrowth)	0	1	2	3
Cystitis	0	1	2	3
Menstrual Disorder (women only)	0	1	2	3

STOMACH ACID PRODUCTION

Pain when eating	0	1	2	3
Pain after eating	0	1	2	3
Heart Burn	0	1	2	3
Metallic acid taste in mouth	0	1	2	3
Bloating after a meal	0	1	2	3
Colic / Reflux	0	1	2	3
Excess burping after a meal	0	1	2	3

Please indicate how many bowel movements you have per day: ____________ & per week: ____________

Are you familiar with using enemas? Y N

If yes, how often? ______________________

Do you use antacids? Y N

Does you take digestive enzymes? Y N

MEDICATIONS

Please list any current prescription or over the counter medications *(ie: antacids, anti depressants, anti inflammatory, blood pressure, cholesterol lowering drugs, diuretics, heart meds, hormones, laxatives, oral contraceptives, steroids, psychotic drugs and thyroid medication).*

Medication	Purpose & how long	Dosage

SUPPLEMENTS

Please list any current supplements *(ie fish oils, probiotics, zinc, B vitamins, humic acids etc).*

Supplement	Brand	Amount	When	How long

MEDICAL

Please list other medical conditions, complications, hospital stays, operations etc.

____

____

TESTS

☐ Organic Acid Test ☐ Comprehensive stool analysis ☐ Hair Analysis

PHYSICIANS

Who is your primary care physician? ____

OTHER SPECIALISTS

____

____

CHEMICAL EXPOSURE

Do you use fluoride tooth paste? Y N

Do you use soaps & other chemical personal care items? Y N

Do you drink unfiltered water? Y N

Do you swim in chlorinated swimming pools? Y N

Do you use strong chemical house hold cleaners and wash powders & detergents? Y N

Do you use sunscreens? Y N

Do you use aluminium cookware? Y N

Do you wrap food in plastic wrap? Y N

Are you renovating your home? Y N

Do you eat non organic foods? Y N

Are you regularly exposed to cigarette smoke? Y N

Do you use air fresheners? Y N

Do you wear perfume? Y N

Have you bought new furniture recently? Y N

Do you use the microwave to heat food? Y N

Alcohol or substance abuse Y N

LEISURE & RECREATION

Please list preferred Leisure and Recreation activities

____

____

NUTRITION & DIET

DIET RESTRICTIONS & FOOD PREFERENCES
Please indicate with a tick in the box, whether you identify with or suspect a problem with the following.

☐ Dysphagia (risk of aspiration)

Explain: ____

☐ Anaphylactic Allergic Reactions ☐ Nuts ☐ Dairy ☐ Nuts

Explain: ____

☐ Food Sensitivities

Explain: ____

☐ Eating Disorder: Anorexia/ Bulimia

Explain: ____

☐ Fussy Eater / Self limits own diet ☐ eats only a handful of foods

Explain: ____

Please list the foods you tend to avid.

____

____

____

____

Please list your preferred foods and snacks

____

____

____

____

Your rate of eating? ☐ Slow ☐ Moderate ☐ Fast ☐ Do not chew food enough

Do you look malnourished? Yes ☐ No ☐ If yes, please describe

____

____

____

____

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NUTRITION ANALYSIS

Food Intake Please record everything you eats & drink over the next three days as accurately as possible. Try to be specific about the food description. Example: was it home made, baked, fried, grilled organic or frozen commercial foods etc. Please include supplements and medications given. Also record behavior issues or any measurable reaction to food.

DAY ONE Name: Date:

BREAKFAST	SUPPLEMENTS/MEDS

MORNING TEA	SUPPLEMENTS/MEDS

LUNCH	SUPPLEMENTS/MEDS

AFTERNOON TEA	SUPPLEMENTS/MEDS

DINNER	SUPPLEMENTS/MEDS

SNACKS	SUPPLEMENTS/MEDS

Is the above an accurate representation of your child's diet? Yes ☐ No ☐ If yes, please describe

BEHAVIOUR / PAIN / OBSERVATIONS

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NUTRITION ANALYSIS

DAY TWO **Name:** **Date:**

BREAKFAST	SUPPLEMENTS/MEDS

MORNING TEA	SUPPLEMENTS/MEDS

LUNCH	SUPPLEMENTS/MEDS

AFTERNOON TEA	SUPPLEMENTS/MEDS

DINNER	SUPPLEMENTS/MEDS

SNACKS	SUPPLEMENTS/MEDS

Is the above an accurate representation of your child's diet? Yes ☐ No ☐ If yes, please describe

BEHAVIOUR / PAIN / OBSERVATIONS

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NUTRITION ANALYSIS

DAY THREE Name: Date:

BREAKFAST	SUPPLEMENTS/MEDS
MORNING TEA	**SUPPLEMENTS/MEDS**
LUNCH	**SUPPLEMENTS/MEDS**
AFTERNOON TEA	**SUPPLEMENTS/MEDS**
DINNER	**SUPPLEMENTS/MEDS**
SNACKS	**SUPPLEMENTS/MEDS**

Is the above an accurate representation of your child's diet? Yes ☐ No ☐ If yes, please describe

BEHAVIOUR / PAIN / OBSERVATIONS

YOUR QUESTIONS

Please record your main questions here and advise on how a nutrition consultant can best support you with GAPS.

ADDITIONAL INFORMATION

Please return post documentation to your GAPS Practitioner in advance (prior to your appointment):