

Current Concerns & Goals

What's bringing you in right now? (In your own words)

Top 5 goals for working together (what would feel like a win for you?):

1. _____
2. _____
3. _____
4. _____
5. _____

Symptom Checklist

- | | | |
|--|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty losing weight |
| <input type="checkbox"/> Brain fog | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Skin issues |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Reflux/heartburn | <input type="checkbox"/> PMS symptoms |
| <input type="checkbox"/> Anxiety or stress intolerance | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Irregular cycles |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sugar cravings | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Low energy between meals | <input type="checkbox"/> Food sensitivities |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Other: _____ |

Sleep & Stress

- | | |
|---|---|
| <input type="checkbox"/> Falling asleep | <input type="checkbox"/> Waking early |
| <input type="checkbox"/> Staying asleep | <input type="checkbox"/> Feeling rested |

Average hours of sleep per night: _____

Stress level (1–10): _____

Main sources of stress in your life: _____

Digestive Health & Bowel Patterns

- | | |
|---|--|
| <input type="checkbox"/> Daily | <input type="checkbox"/> Hard stools |
| <input type="checkbox"/> Every other day | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Every 3–5 days | <input type="checkbox"/> Incomplete emptying |
| <input type="checkbox"/> Less than every 5 days | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Straining | <input type="checkbox"/> Mucus |

Nutrition & Eating Patterns

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Food Preferences & Vices

Proteins you enjoy: _____

Vegetables you enjoy: _____

Fruits you enjoy: _____

Carbohydrates/starches you enjoy: _____

Fats you enjoy: _____

Alcohol frequency: Rare Weekly Several/week Daily

Sweets/snacks frequency: Rare Weekly Daily

Favorite indulgences or comfort foods: _____

Menstrual Health (if applicable)

Regular Irregular Painful Heavy Menopause/Perimenopause

PMS symptoms: _____

Physical Activity

Type of movement: _____

Days per week: _____

Liver & Gallbladder Clues

- | | |
|---|---|
| <input type="checkbox"/> Upper right abdominal discomfort | <input type="checkbox"/> History of gallstones or polyps |
| <input type="checkbox"/> Pain after fatty meals | <input type="checkbox"/> Fatty liver history |
| <input type="checkbox"/> Nausea after eating | <input type="checkbox"/> Constipation without urge |
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Sensitivity to fats or supplements |
| <input type="checkbox"/> Pale or floating stools | |

Readiness & Obstacles

Readiness for change (1–10): _____

Biggest obstacle right now (what feels hardest?):

Thank you for taking the time to share this. Your responses help me create a plan that truly fits you.

Carrie Wojo | Path to Health | Feed Your Body So It Can Heal Itself!