The Myers Way® SIBO Breakthrough™ Program

Symptoms Quiz

Each week you will rate your symptoms to calculate your overall level of inflammation.

Record your weekly score in your Progress Tracker to measure your progress.

Rate the following symptoms on a scale of 0-4, based on severity. Your answers will provide a clear baseline as you embark on your journey to better health.

0 = None
1 = Some
2 = Mild
3 = Moderate
4 = Severe

HEAD	MIND
___ headaches ___ migraines ___ dizziness ___ faintness ___ trouble sleeping Total: ____	___ brain fog ___ poor memory ___ impaired coordination ___ difficulty deciding ___ slurred/stuttered speech ___ learning/ attention deficit Total: ____
NOSE	**EARS**
___ nasal congestion ___ excessive mucus ___ stuffy/runny nose ___ sinus problems ___ frequent sneezing Total: ____	___ itchy ears ___ earaches, infections ___ drainage from ear ___ ringing, hearing loss Total: ____
HEART	**LUNGS**
___ irregular heartbeat ___ fast heart rate ___ chest pain Total: ____	___ chest congestion ___ asthma, bronchitis ___ shortness of breath ___ difficulty breathing Total: ____

Page 1 Total:

EYES	WEIGHT	ENERGY/ACTIVITY
___ swollen, red eyelids ___ dark circles ___ puffy eyes ___ poor vision ___ watery, itchy eyes Total: ____	___ inability to lose weight ___ food cravings ___ overweight ___ underweight ___ compulsive eating ___ water retention/ swelling Total: ____	___ fatigue ___ lethargy ___ hyperactivity ___ restlessness Total: ____
MOUTH/THROAT	**DIGESTION**	**JOINTS/MUSCLES**
___ chronic cough ___ clear throat frequently ___ sore throat ___ swollen lips ___ canker sores Total: ____	___ nausea/vomiting ___ diarrhea ___ constipation ___ bloating ___ belching/passing gas ___ heartburn/ indigestion ___ intestinal/stomach pain or cramps Total: ____	___ pain/aching joints ___ arthritis ___ muscle stiffness ___ pain/muscle aches ___ weakness/tiredness Total: ____
SKIN	**EMOTIONS**	**OTHER**
___ acne ___ hives, eczema, dry skin ___ hair loss ___ hot flashes ___ excessive sweating Total: ____	___ anxiety ___ depression ___ mood swings ___ nervousness ___ easily irritated Total: ____	___ frequent illness/ infections ___ frequent/urgent urination ___ genital itch, discharge Total: ____

Page 2 Total:

Grand Total:

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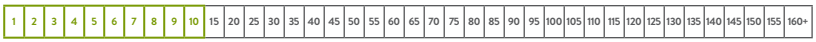
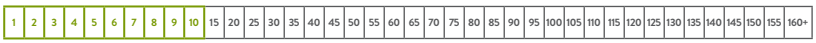
Progress Tracker

SYMPTOM QUIZ TOTAL

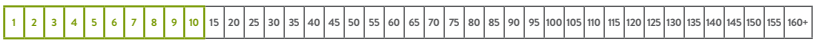
Tally up your symptom score each week using your Symptoms Quiz. Color in each bar to see your progress!



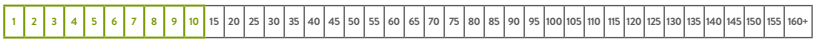
Week 1 Total: _____



Week 2 Total: _____



Week 3 Total: _____



Week 4 Total: _____

AVERAGE SLEEP

Week 1	hrs/night
Week 2	hrs/night
Week 3	hrs/night
Week 4	hrs/night

WEEKLY WEIGH-IN

Week 1	
Week 2	
Week 3	
Week 4	