

Patient Follow-Up Questionnaire

Name: _____ Date: _____

What day in your journal are you on? Day _____

Are you more or less comfortable in your gut during the day and/or at bedtime? _____

Have your bowel movements increased, decreased or stayed the same? Explain. _____

Has your sleep pattern changed? Sleeping more or less? _____

How is your energy throughout the day? _____

Are you having difficulty with the diet? Any challenges? _____

Are you having difficulty with the protocol? _____

Overall, what changes in your health are you experiencing? _____
