



the better nutrition digestive evaluation

~~"YOU ARE WHAT YOU EAT."~~

You ARE what you digest and absorb.

1) What's happening or not in the bathroom?

DAILY | **OFTEN** | **NEVER**
>4 days/week 2-3 days/wk <1 day monthly

a. #1 once a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. # 2 once a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you strain to go #1 or #2?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you feel like you need to but can't go #1 or #2?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you see undigested food in your #2?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Is your #2 pellets instead of a fully formed (S shape)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Is there blood when you wipe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Are you relying on band-aids to help digestion & elimination			
- caffeine, cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- medications (Rx or over-the-counter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- colonics, detoxes, cleanses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2) Are things going in the right direction:

a. Are your things (food, acid, liquids) going the wrong way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have reflux; are you taking medication for GERD?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you have loose stools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Are you bloated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3) Do you smell as lovely as you are:

a. Do you have foul or sweet smelling gas, poop or body odor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

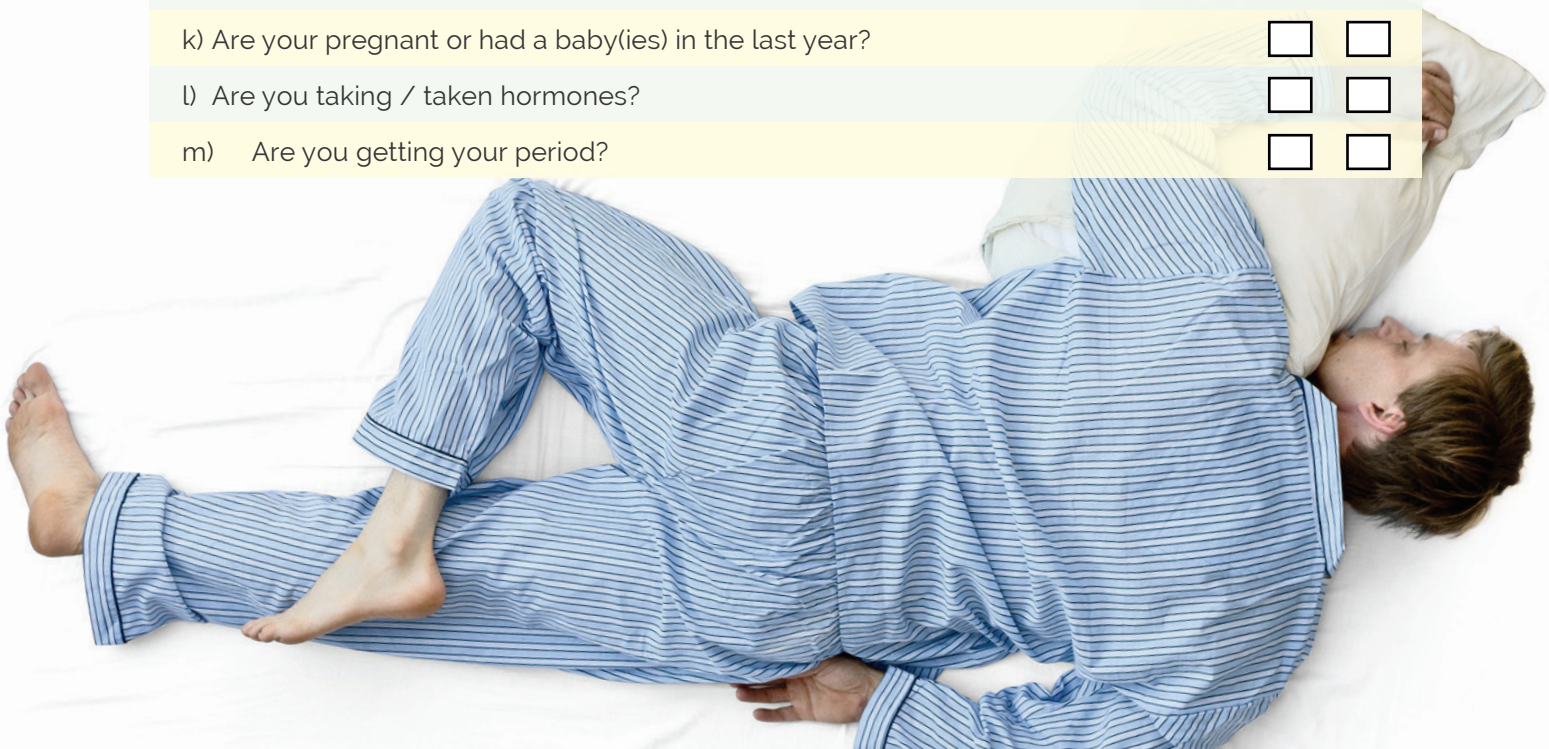
4) Is your nutrition working better for you:

YES | NO

a. Do you eat better quantities, nutrient balance but still feel hungry soon after?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have low energy after eating?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you struggle to lose weight around your middle even though you make better nutrition choices and exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you feel bloated after eating?	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you get in your better water amount daily?	<input type="checkbox"/>	<input type="checkbox"/>
f. Do you avoid foods due to allergies, intolerances?	<input type="checkbox"/>	<input type="checkbox"/>
g. Do you skip foods / food groups because you don't digest them well?	<input type="checkbox"/>	<input type="checkbox"/>
h. Do you get in a rainbow of colors from plants?	<input type="checkbox"/>	<input type="checkbox"/>

5) Is your life challenging your digestive health?

a) Do you travel where you sit >20 minutes daily?	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you travel on a plane?	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you stressed (are you a >5 on a scale of 1-10)	<input type="checkbox"/>	<input type="checkbox"/>
d) Do you struggle to get 7 hours of good sleep?	<input type="checkbox"/>	<input type="checkbox"/>
e) Do you exercise vigorously?	<input type="checkbox"/>	<input type="checkbox"/>
f) Do you sit for >2 hours at a time?	<input type="checkbox"/>	<input type="checkbox"/>
g) Do you have an injury or illness that keeps you from twisting your upper body (waist), touching your toes, taking steps?	<input type="checkbox"/>	<input type="checkbox"/>
h) Are you more than 10 pounds overweight?	<input type="checkbox"/>	<input type="checkbox"/>
i) Do you have a chronic digestive disease or condition?	<input type="checkbox"/>	<input type="checkbox"/>
j) Do you have a history of taking antibiotics, anti-depressants, birth control, or skin medications (topical or oral)?	<input type="checkbox"/>	<input type="checkbox"/>
k) Are you pregnant or had a baby(ies) in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
l) Are you taking / taken hormones?	<input type="checkbox"/>	<input type="checkbox"/>
m) Are you getting your period?	<input type="checkbox"/>	<input type="checkbox"/>



6) Is your digestive system protecting you:

YES | NO

a. Do you get yeast, sinus, or ear / throat infections?

☐ ☐

b. Are you taking antibiotics? oral or topical?

☐ ☐

c. Do you get a cold(s) > 1 quarterly (every 3 months)?

☐ ☐

7) Is your skin telling you something?

a. Are you breaking out (back, bum, face, arms)?

☐ ☐

b. Do you have bags or dark color under your eyes?

☐ ☐

c. Do you have eczema or chronic skin disease?

☐ ☐

d. Do you have white bumps on your arms?

☐ ☐

8) Are your supplements affecting your digestion?

a. Do you take a multivitamin?

☐ ☐

b. Do you take a calcium or iron supplement?

☐ ☐

c. Do you take magnesium?

☐ ☐

d. Do you take a probiotic?

☐ ☐

e. Do you take glutamine or collagen?

☐ ☐

f. Are you getting enough fiber?

☐ ☐

g. Do you take a fiber or prebiotic fiber supplement?

☐ ☐

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NOTES:



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All materials developed and reviewed by Ashley Koff RD at times in conjunction with other leading healthcare practitioners.
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