Personal Inventory (Pre-Whole 30)\*

Set your intention in doing the Whole 30…

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the following symptoms that you have experienced **in the last few months** and add any measurable details such as **frequency, what aggravates these symptoms** (that you know of!). Also rate them 1/10 (10 being the worst ever).

|  |  |  |  |
| --- | --- | --- | --- |
| CONDITION |  | DETAILS | Rating |
| Anxiety |  |  |  |
| Arthritis/Inflammation |  |  |  |
| Asthma |  |  |  |
| Atelectasis/Bronchitis |  |  |  |
| Autoimmune Disorders |  |  |  |
| Bloating/Gas |  |  |  |
| Fatigue |  |  |  |
| Diarrhea |  |  |  |
| Constipation |  |  |  |
| Depression |  |  |  |
| Dizziness |  |  |  |
| Gastric Upset, GERD |  |  |  |
| Headaches |  |  |  |
| High Blood Pressure |  |  |  |
| Irritable Bowel Syndrome |  |  |  |
| Menstrual Disorders |  |  |  |
| Muscle/Joint/Bone Pain |  |  |  |
| Nausea |  |  |  |
| Restless Legs |  |  |  |
| Sinusitis/Allergies |  |  |  |
| Skin Conditions |  |  |  |
| Thyroid Imbalance |  |  |  |
| Other (please describe) |  |  |  |

TYPICAL SLEEPING PATTERNS (most of the time):

Are you going to bed and waking at the same time everyday? Y or N

Do you wake refreshed? Y or N

Do you fall asleep within the first 15 minutes of trying? Y or N

ELIMINATION:

How many times are you having a bowel movement daily (weekly if constipated)? \_\_\_\_\_\_\_\_

Choose 3-4 symptoms that you would like to see improved. Next to the symptoms, rate your symptom from 1-10 (10 being the worst its ever been). (For instance: Sinusitis 6/10)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Please circle your current stress level (0 none, 10 extremely stressful)

0—-1—-2—-3—-4—-5—-6—-7—-8—-9—-10

How would you describe your general state of health? (please circle one)

excellent -— good ——- fair ——- poor

\*Consult with your medical doctor or nutritionist to make sure this diet is right for you!