PROBIOTIC HERBS SLEEPING FORMULA—SELF-CHECK QUESTIONNAIRE

NAME

DAY 1

Rate your symptoms on a scale of 10 (extreme) down to 1 (minimal).
Place your score in the right hand column and add up your total.

DATE / /

SYMPTOM	SCALE	10	9	8	7	6	5	4	3	2	1	SCORE
NO OF HOURS OF SLEEP	10											0
NO OF TIMES WAKE UP AT NIGHT	Often											Never
TIME TO GET TO SLEEP	Long Time											No Time At All
FEELING ON WAKING	Very Tired											Refreshed
DAYTIME ENERGY LEVELS	Very Low											Consistently Good
SUGAR CRAVINGS	Use Sugar Daily											Don't Use Sugar
MOOD SWINGS	Very Moody											Balanced and Good
ANXIOUS	Very Anxious											Calm
EMOTIONAL	Highly Strung											Balanced
FEELINGS OF HOPELESSNESS	Depressed											Life is Good
SHORT TERM MEMORY	Forget Things Easily											Great Memory
FOCUS	Not Focussed											Very Focussed
HOT FLUSHES	Many Daily											Rarely
NIGHT SWEATS	Many											Rarely
SEX DRIVE	Very Low											High
HEADACHES/MIGRAINES	Extreme											Rarely
MENSTRUAL CRAMPS/PAIN	Very Painful											No Pain
JOINT PAIN	Very Painful											No Pain
WEIGHT	Overweight											Slim
ACNE/SKIN CONDITIONS	Extreme											None
RESTLESS LEGS	Often											Never
BLOATING/WIND	Daily											Never
BOWEL MOVEMENTS	Not Daily											1-3 Per Day
INDIGESTION/UPSET STOMACH	Daily											No Problem
IRRITABLE BOWEL SYNDROME	Severe											No Problem
PERSONAL CONDITION	Extreme											Minimal
OTHER	Extreme											Minimal

SUPPORT
Phone Mon to Fri **(07) 554 66 086**
Email **info@probioticfoods.com.au**

CURRENT WEIGHT

SCORE TOTAL

PROBIOTIC HERBS SLEEPING FORMULA—SELF-CHECK QUESTIONNAIRE

NAME

DAY 30

Rate your symptoms on a scale of 10 (extreme) down to 1 (minimal).
Place your score in the right hand column and add up your total.

DATE / /

SYMPTOM	SCALE	10	9	8	7	6	5	4	3	2	1	SCORE
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OTHER	Extreme											Minimal

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CURRENT WEIGHT

SCORE TOTAL