Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____

PART I *Please list up to 5 of your health concerns in order of importance*

1 _____

2 _____

3 _____

4 _____

5 _____

PART II *Please check (**X**) how frequently you experience the following:*

0 (never) **1 (seldom)** **2 (frequent)** **3 (always)**

Category 1	
Feeling that bowels do not empty completely	0 1 2 3
Abdominal pain relieved by passing gas or stool	0 1 2 3
Constipation	0 1 2 3
Diarrhea	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Hard, dry or small stool	0 1 2 3
Coated or fuzzy tongue	0 1 2 3
Pass large amounts of foul smelling gas	0 1 2 3
More than 3 bowel movements per day	0 1 2 3
Laxitive use	0 1 2 3

Category II	
Excessive belching, burping or bloating	0 1 2 3
Gas immediately following meals	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during or after meals	0 1 2 3
Difficulty digesting fruits / vegetables	0 1 2 3
Undigested food in stool	0 1 2 3

Category III	
Stomach pain or burning 1 - 4 hours after eating	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Antacid use	0 1 2 3
Digestive problems subside with rest / relaxation	0 1 2 3
Relief of stomach pain from milk or carbonated beverages	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, caffeine	0 1 2 3

Category IV	
Roughage and fiber cause constipation	0 1 2 3
Indigestion or fullness lasting 2 - 4 hours after eating	0 1 2 3
Pain or tenderness on left side under rib cage	0 1 2 3
Excessive gas	0 1 2 3
Nausea / vomiting	0 1 2 3
Foul smelling, mucous-like or poorly formed stool	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst or appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category V	
Greasy or fatty foods cause distress	0 1 2 3
Lower bowel gas / bloating	0 1 2 3
Bitter metallic taste in mouth	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellow cast to eyes	0 1 2 3
Clay colored stool	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin or hair	0 1 2 3
History of gall bladder attacks or stones	0 1 2 3
Has your gall bladder been removed?	Yes No

Category VI	
Crave sweets	0 1 2 3
Irritable or lightheaded if meals are missed	0 1 2 3
Depend on coffee to get started or keep going	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky or jittery	0 1 2 3
Feel agitated, nervous, or upset easily	0 1 2 3
Poor memory / forgetful	0 1 2 3

Category VII	
Fatigue or sleepiness after meals	0 1 2 3
Crave sweets	0 1 2 3
Eating sweets does not relieve sugar cravings	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth equal or larger than hip girth	0 1 2 3

Category VIII	
Wake frequently at night	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category IX

Difficulty falling asleep	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6+ hours of sleep	0	1	2	3
Excessive perspiration w/ little activity	0	1	2	3
Perspire easily	0	1	2	3

Category X

Tired / sluggish	0	1	2	3
Feel cold especially hands & feet	0	1	2	3
Require excessive amounts of sleep	0	1	2	3
Weight gain even with low calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult / infrequent bowel movements	0	1	2	3
Depression / lack of motivation	0	1	2	3
Morning headaches that wear off throughout the day	0	1	2	3
Thinning of outer third of eyebrow	0	1	2	3
Thinning or falling out of hair	0	1	2	3
Dryness of skin or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders	0	1	2	3
Lack of menstruation	0	1	2	3
Increased ablitiy to eat sugar without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Reduced tolerance to sugar	0	1	2	3
"Splitting" headaches	0	1	2	3

Category XIV (male only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain down inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (male only)

Decreased libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increased fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (menstruating females only)

Menopausal symptoms	0	1	2	3
Alternating menstrual cycle lengths	0	1	2	3
Extended menstrual cycle (longer than 32 days)	0	1	2	3
Shortened menstrual cycle (less than 24 days)	0	1	2	3
Pain and cramping during menses	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3

Category XVII (menopausal females only)

How many years have you been menopausal _____

Do you ever have uterine bleeding	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Vaginal pain, dryness, itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ____
How many times do you eat out per week? ____
How many times per week do you eat fish? ____
List the 3 healthiest foods you eat during the average week _____
List the 3 worst foods you eat during the average week _____
Rate your stress level on a scale of 1 - 10 during an average week ____

How many caffeinated beverages do you consume per day? ____
How many times per week do you eat raw nuts or seeds? ____
How many times per week do you exercise? ____

Circle any of the following medications that you are currently taking or have taken in the past year

Antacids	Antihistamines	Birth control pills or patch	Hormone replacement
Antibiotics	Anti-inflammatories	Diuretics	Hydrocortisone cream
Antidepressants	Anxiety medication	High blood pressure meds	Thyroid meds
Antifungals	Aspirin / Tylenol	High cholesterol meds	Others: _____