

Metabolic Assessment Form

Name (Printed): _____ Age: _____ Sex: M / F Date: _____

PART I: Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II: Please circle the appropriate number on all questions below. (0 = the least/ never to 3= most/ always)

<u>Category I</u>		<u>Category V</u>	
Feeling that bowels do not empty completely	0 1 2 3	Greasy or high fat foods cause distress	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3	Lower bowel gas and/ or bloating several hours after eating	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3	Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Diarrhea	0 1 2 3	Unexplained itchy skin	0 1 2 3
Constipation	0 1 2 3	Yellowish cast to eyes	0 1 2 3
Hard, dry or small stool	0 1 2 3	Stool color alternates from clay colored to normal brown	0 1 2 3
Coated tongue, "fuzzy" debris on tongue	0 1 2 3	Reddened skin, especially palms of hands	0 1 2 3
Pass large amounts of foul smelling gas	0 1 2 3	Dry or flaky skin and/ or hair	0 1 2 3
More than 3 bowel movements per day	0 1 2 3	History of gallbladder attacks or stones	0 1 2 3
Frequent use of laxatives	0 1 2 3	Have you had your gallbladder removed	Yes No
<u>Category II</u>		<u>Category VI</u>	
Excessive belching, burping or bloating	0 1 2 3	Crave sweets during the day	0 1 2 3
Gas, immediately following a meal	0 1 2 3	Irritable if meals are missed	0 1 2 3
Offensive smelling breath	0 1 2 3	Depend on coffee to get self started or keep going during day	0 1 2 3
Difficult bowel movements	0 1 2 3	Get lightheaded if meals are missed	0 1 2 3
Sense of fullness during and after meals	0 1 2 3	Eating relieves fatigue	0 1 2 3
Difficulty digesting fruits and vegetables; undigested food found in stools	0 1 2 3	Feel shaky, jittery, tremors	0 1 2 3
<u>Category III</u>		<u>Category VII</u>	
Stomach pain, burning or aching, 1-4 hours after eating	0 1 2 3	Agitated, easily upset, nervous	0 1 2 3
Frequent use of antacids	0 1 2 3	Poor memory, forgetful	0 1 2 3
Feeling hungry 1-2 hours after eating	0 1 2 3	Blurred vision	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3	<u>Category VIII</u>	
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3	Fatigue after meals	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3	Crave sweets during the day	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers alcohol, and caffeine	0 1 2 3	Eating sweets does not relieve cravings for sugar	0 1 2 3
<u>Category IV</u>		<u>Category IX</u>	
Constipation caused by roughage and fiber	0 1 2 3	Must have sweets after meals	0 1 2 3
Indigestion and fullness lasts 2- 4 hours after eating	0 1 2 3	Waist girth is equal to/ larger than hip girth	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3	Frequent urination	0 1 2 3
Excessive passage of gas	0 1 2 3	Increased thirst and appetite	0 1 2 3
Nausea and/ or vomiting	0 1 2 3	Difficulty losing weight	0 1 2 3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0 1 2 3	<u>Category X</u>	
Frequent Urination	0 1 2 3	Cannot stay asleep	0 1 2 3
Increased thirst and appetite	0 1 2 3	Crave salt	0 1 2 3
Difficulty losing weight	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 finger nails and toe nails	0 1 2 3

Category IX				
Cannot fall asleep	0	1	2	3
Perspire easily	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 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with a 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 as day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair falling out	0	1	2	3
Dryness of skin and/ 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 or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males Only)				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain 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 (Males Only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of 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
Increase in 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)				
Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Extremely light blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/ thinning	0	1	2	3

Category XVII (Menopausal Females Only)				
How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?	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
Increased vaginal pain, dryness, or 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 a week do you eat fish? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

Do you smoke? Yes No If yes, how many times per day: _____

How many caffeinated beverages do you consume per day? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you work out? _____

Rate your stress level from 1 – 10 on an average week: _____

Please list any medications your are currently taking, and the condition(s) they are meant to treat: _____

Please list any supplements you are currently taking, and the condition(s) they are meant to treat: _____