

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

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

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

PART II

Please circle the appropriate number "0 - 3" on all questions below.

0 as the least/never, 1 as occasional, 2 as frequent and 3 as the most/always.

<p>Category I 30</p> <p>Feeling that bowels do not empty completely 0 1 2 3</p> <p>Low abdominal pain relief by passing stool or gas 0 1 2 3</p> <p>Alternating constipation and diarrhea 0 1 2 3</p> <p>Diarrhea 0 1 2 3</p> <p>Constipation 0 1 2 3</p> <p>Hard dry or small stool 0 1 2 3</p> <p>Coated tongue of "fuzzy" debris on tongue 0 1 2 3</p> <p>Pass large amount of foul smelling gas 0 1 2 3</p> <p>More than 3 bowel movements daily 0 1 2 3</p> <p>Do you use laxatives frequently 0 1 2 3</p> <p>Category II 18</p> <p>Excessive belching, burping or bloating 0 1 2 3</p> <p>Gas immediately following a meal 0 1 2 3</p> <p>Offensive breath 0 1 2 3</p> <p>Difficult bowel movements 0 1 2 3</p> <p>Sense of fullness during and after meals 0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested foods found in stools 0 1 2 3</p> <p>Category III 21</p> <p>Stomach pain, burning or aching 1-4hrs after eating 0 1 2 3</p> <p>Do you frequently use antacids? 0 1 2 3</p> <p>Feeling hungry an hour or two after eating 0 1 2 3</p> <p>Heartburn when lying down or bending forward 0 1 2 3</p> <p>Temporary relief from antacids, food, milk and /or carbonated beverages 0 1 2 3</p> <p>Digestive problems subside with rest & relaxing 0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine 0 1 2 3</p> <p>Category IV 30</p> <p>Roughage and fiber cause constipation 0 1 2 3</p> <p>Indigestion and fullness lasts 2-4 hours after eating 0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage bloated 0 1 2 3</p> <p>Excessive passage of gas 0 1 2 3</p> <p>Nausea and/or vomiting 0 1 2 3</p> <p>Stool undigested, foul smelling, mucous-like, greasy or poorly formed 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst and appetite 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p>	<p>Category V 27</p> <p>Greasy or high fat foods cause distress 0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating 0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning 0 1 2 3</p> <p>Unexplained itchy skin 0 1 2 3</p> <p>Yellowish cast to eyes 0 1 2 3</p> <p>Stool color alternates for clay colored to normal brown 0 1 2 3</p> <p>Reddened skin, especially palms 0 1 2 3</p> <p>Dry or flaky skin and/or hair 0 1 2 3</p> <p>History of gallbladder attacks or stones 0 1 2 3</p> <p>Have you had your gallbladder removed? Yes No</p> <p>Category VI 27</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Irritable if meals are missed 0 1 2 3</p> <p>Depend on coffee to keep yourself going or started 0 1 2 3</p> <p>Get lightheaded and if meals are missed 0 1 2 3</p> <p>Eating relieves fatigue 0 1 2 3</p> <p>Feel shaky, jittery, tremors 0 1 2 3</p> <p>Agitated, easily upset, nervous 0 1 2 3</p> <p>Poor memory, forgetful 0 1 2 3</p> <p>Blurred vision 0 1 2 3</p> <p>Category VII 24</p> <p>Fatigue after meals 0 1 2 3</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar 0 1 2 3</p> <p>Must have sweets after meals 0 1 2 3</p> <p>Waist girth is equal or larger than hip girth 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst & appetite 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p> <p>Category VIII 24</p> <p>Cannot stay asleep 0 1 2 3</p> <p>Crave salt 0 1 2 3</p> <p>Slow starter in the morning 0 1 2 3</p> <p>Afternoon fatigue 0 1 2 3</p> <p>Dizziness when standing up quickly 0 1 2 3</p> <p>Afternoon headaches 0 1 2 3</p> <p>Headaches with exertion or stress 0 1 2 3</p> <p>Weak nails 0 1 2 3</p>
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Category IX	18				Category XIV (Male Only)	15			
Cannot fall asleep	0	1	2	3	Urination difficulty or dribbling	0	1	2	3
Perspire easily	0	1	2	3	Urination frequent	0	1	2	3
Under high amounts of stress	0	1	2	3	Pain inside of legs or heels	0	1	2	3
Weight gain when under stress	0	1	2	3	Feeling of incomplete bowel evacuation	0	1	2	3
Wake up tired even after 6 or more hrs of sleep	0	1	2	3	Leg nervousness at night	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3	Category XV (Males Only)	39			
Category X	36				Decrease in libido	0	1	2	3
Tired, sluggish	0	1	2	3	Decrease in spontaneous morning erections	0	1	2	3
Feel cold - hands, feet, all over	0	1	2	3	Decrease in fullness of erections	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3	Difficulty in maintain morning erections	0	1	2	3
Increase weight gain even with low-calorie diet	0	1	2	3	Spells of mental fatigue	0	1	2	3
Gain weight easily	0	1	2	3	Inability to concentrate	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3	Episodes of depression	0	1	2	3
Depression, lack of motivation	0	1	2	3	Muscle soreness	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3	Decrease in physical stamina	0	1	2	3
Outer third of eyebrow thins	0	1	2	3	Unexplained weight gain	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3	Increase fat distribution around chest & hips	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3	Sweating attacks	0	1	2	3
Mental sluggishness	0	1	2	3	More emotional than in the past	0	1	2	3
Category XI	21				Category XVI (Menstruating Females Only)	27			
Heart palpitations	0	1	2	3	Are you currently menopausal?	Yes	No		
Inward trembling	0	1	2	3	Alternating menstrual cycle lengths	Yes	No		
Increased pulse even at rest	0	1	2	3	Long menstrual cycle, greater than 32 days	Yes	No		
Nervousness and emotional	0	1	2	3	Shortened menses, less than every 24 days	Yes	No		
Insomnia	0	1	2	3	Pain and cramping during periods	0	1	2	3
Night sweats	0	1	2	3	Scanty blood flow	0	1	2	3
Difficulty gaining weight	0	1	2	3	Heavy blood flow	0	1	2	3
Category XII	9				Breast pain and swelling during menses	0	1	2	3
Diminished sex drive	0	1	2	3	Pelvic pain during menses	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3	Irritable and depressed during menses	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3	Acne break outs	0	1	2	3
Category XIII	9				Facial hair growth	0	1	2	3
Increased sex drive	0	1	2	3	Hair loss/thinning	0	1	2	3
Tolerance to sugars reduced	0	1	2	3	Category XVII (Menopausal Females only)	30			
"Splitting" type headaches	0	1	2	3	How many years have you been menopausal?				
					Do you have uterine bleeding since menopause?	Yes	No		
					Hot flashes	0	1	2	3
					Mental foginess	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 breast	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 alcohol beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

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

How many times a week do you eat fish? _____ How many times a week do you workout? _____

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? _____ If yes, how many times a day _____, a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

Please list any medications you currently take and for what conditions: _____