

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

**Please circle the appropriate number “0 - 3” on all questions below. 0 as the least/never to 3 as the most/always.**

<b>Category I</b>			
Feeling that bowels do not empty completely . . . . .	0	1	2 3
Lower abdominal pain relief by passing stool or gas .	0	1	2 3
Alternating constipation and diarrhea . . . . .	0	1	2 3
Diarrhea . . . . .	0	1	2 3
Constipation . . . . .	0	1	2 3
Hard, dry, or small stool . . . . .	0	1	2 3
Coated tongue of “fuzzy” debris on tongue . . . . .	0	1	2 3
Pass large amount of foul smelling gas . . . . .	0	1	2 3
More than 3 bowel movements daily . . . . .	0	1	2 3
Use laxatives frequently . . . . .	0	1	2 3
<b>Category II</b>			
Excessive belching, burping, or bloating . . . . .	0	1	2 3
Gas immediately following a meal . . . . .	0	1	2 3
Offensive breath . . . . .	0	1	2 3
Difficult bowel movements . . . . .	0	1	2 3
Sense of fullness during and after meals . . . . .	0	1	2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools . . . . .	0	1	2 3
<b>Category III</b>			
Stomach pain, burning, or aching 1- 4 hours after eating . . . . .	0	1	2 3
Do you frequently use antacids? . . . . .	0	1	2 3
Feeling hungry an hour or two after eating . . . . .	0	1	2 3
Heartburn when lying down or bending forward . . . . .	0	1	2 3
Temporary relief from antacids, food, milk, carbonated beverages . . . . .	0	1	2 3
Digestive problems subside with rest and relaxation .	0	1	2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine . . . . .	0	1	2 3
<b>Category IV</b>			
Roughage and fiber cause constipation . . . . .	0	1	2 3
Indigestion and fullness lasts 2-4 hours after eating . . . . .	0	1	2 3
Pain, tenderness, soreness on left side under rib cage . . . . .	0	1	2 3
Excessive passage of gas . . . . .	0	1	2 3
Nausea and/or vomiting . . . . .	0	1	2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed . . . . .	0	1	2 3
Frequent urination . . . . .	0	1	2 3
Increased thirst and appetite . . . . .	0	1	2 3
Difficulty losing weight . . . . .	0	1	2 3

<b>Category V</b>			
Greasy or high fat foods cause distress . . . . .	0	1	2 3
Lower bowel gas and or bloating several hours after eating . . . . .	0	1	2 3
Bitter metallic taste in mouth, especially in the morning . . . . .	0	1	2 3
Unexplained itchy skin . . . . .	0	1	2 3
Yellowish cast to eyes . . . . .	0	1	2 3
Stool color alternates from clay colored to normal brown . . . . .	0	1	2 3
Reddened skin, especially palms . . . . .	0	1	2 3
Dry or flaky skin and/or hair . . . . .	0	1	2 3
History of gallbladder attacks or stones . . . . .	0	1	2 3
Have you had your gallbladder removed . . . . .	Yes	No	
<b>Category VI</b>			
Crave sweets during the day . . . . .	0	1	2 3
Irritable if meals are missed . . . . .	0	1	2 3
Depend on coffee to keep yourself going or started .	0	1	2 3
Get lightheaded if meals are missed . . . . .	0	1	2 3
Eating relieves fatigue . . . . .	0	1	2 3
Feel shaky, jittery, tremors . . . . .	0	1	2 3
Agitated, easily upset, nervous . . . . .	0	1	2 3
Poor memory, forgetful . . . . .	0	1	2 3
Blurred vision . . . . .	0	1	2 3
<b>Category VII</b>			
Fatigue after meals . . . . .	0	1	2 3
Crave sweets during the day . . . . .	0	1	2 3
Eating sweets does not relieve cravings for sugar . . .	0	1	2 3
Must have sweets after meals . . . . .	0	1	2 3
Waist girth is equal or larger than hip girth . . . . .	0	1	2 3
Frequent urination . . . . .	0	1	2 3
Increased thirst & appetite . . . . .	0	1	2 3
Difficulty losing weight . . . . .	0	1	2 3
<b>Category VIII</b>			
Cannot stay asleep . . . . .	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

<b>Category IX</b>				
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
<b>Category X</b>				
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 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 the 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 falling hair . . . . .	0	1	2	3
Dryness of skin and/or scalp . . . . .	0	1	2	3
Mental sluggishness . . . . .	0	1	2	3
<b>Category XI</b>				
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
<b>Category XII</b>				
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
<b>Category XIII</b>				
Increased sex drive . . . . .	0	1	2	3
Tolerance to sugars reduced . . . . .	0	1	2	3
“Splitting” type headaches . . . . .	0	1	2	3

<b>Category XIV (Males only)</b>				
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
<b>Category XV (Males only)</b>				
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 maintain 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
<b>Category XVI (Menstruating Females Only)</b>				
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
Scanty 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
<b>Category XVII (Menopausal Females Only)</b>				
How many years have you been menopausal? . . . . .				
Since menopause, 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
Increased vaginal pain, dryness or itching . . . . .	0	1	2	3

How many alcohol 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? \_\_\_\_\_ If yes, how many times a day: \_\_\_\_\_

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:**

**Please list any natural supplements you currently take and for what conditions:**