

METABOLIC ASSESSMENT FORM

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

PART I

Please list your 3 major health concerns in your order of importance: 1) _____ 2) _____ 3) _____	List any pills you take & the reason why: _____ _____ _____
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PART II

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

0 = never, 1 = occasionally, 2 = somewhat frequently, 3 = very frequently

Category I: Colon

- 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
- Do you use laxatives frequently 0 1 2 3

Category II: Hypochlorydia

- 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

Category III: Hyperacidity (Ulcer)

- 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

Category IV: Small Intestine (Pancreas)

- 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 bloated 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

Category V: Biliary Insufficiency/Stasis

- 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

Category VI: Hypoglycemia

- 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 and 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

Category VII: Insulin Resistance

- 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 Yes No
- Frequent urination 0 1 2 3
- Increased thirst & appetite 0 1 2 3
- Difficulty losing weight 0 1 2 3

Category VIII: Adrenal Hypofunction

- 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

Category IX: Adrenal Hyperfunction

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: Hypothyroid

Tired, sluggish	0	1	2	3
Feel cold – hands, feel, 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

Category XI: Thyroid Hyperfunction

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: Pituitary Hypofunction

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: Pituitary Hyperfunction

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Male 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): Male Physiology

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

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
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

Date of last menstrual period: _____

Date of last Pap: _____

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 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

Date of last menstrual period: _____

Date of last Pap: _____

Part III:

How were you referred to our office? _____ What is your occupation? _____

How many alcohol beverages they 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? _____, how many packs per day? _____. Rate your stress level on a scale of 1-10 for an average week: _____

Do you have any disease/illness (cancer, autoimmune disease, diabetes, stroke, heart disease, etc):

Do any diseases or illness "run in your family" (cancer, autoimmune disease, diabetes, stroke, heart disease, etc):

Do you have any children? _Yes _No; Do they have any health problems?

Have you ever had a head injury? _Yes _No