

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ 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 “0 - 3” on all questions below. **0 as the least/never to 3 as the most/always.**

Category I				
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
Category II				
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				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel 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				
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

Category V				
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				
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, or have 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				
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 and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VIII				
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

*Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.*

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 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

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
Frequent urination	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
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 breakouts	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?	_____			
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

PART III

How many alcoholic 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: _____

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: