# 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.

### 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
- Difficultly digesting fruits and vegetables; undigested foods found in stools ........... 0 1 2 3

### Category III

- Stomach pain, burning, or achy 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, mucus-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 ........................ 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
<table>
<thead>
<tr>
<th>Category IX</th>
<th>Category XIV (Males only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot fall asleep                      0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Perspire easily                         0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Under high amounts of stress            0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Weight gain when under stress           0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Wake up tired even after 6 or more hours of sleep 0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Excessive perspiration or perspiration with little or no activity 0 1 2 3</td>
<td></td>
</tr>
<tr>
<td><strong>Category X</strong></td>
<td><strong>Category XIV (Males only)</strong></td>
</tr>
<tr>
<td>Tired, sluggish                          0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Feel cold – hands, feet, all over        0 1 2 3</td>
<td></td>
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<tr>
<td>Require excessive amounts of sleep to function properly 0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Increase in weight gain even with low-calorie diet 0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Gain weight easily                       0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>Difficult, infrequent bowel movements    0 1 2 3</td>
<td></td>
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<tr>
<td>Depression, lack of motivation           0 1 2 3</td>
<td></td>
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<tr>
<td>Morning headaches that wear off as the day progresses 0 1 2 3</td>
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<tr>
<td>Outer third of eyebrow thins             0 1 2 3</td>
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<tr>
<td>Thinning of hair on scalp, face, or genitals or excessive falling hair 0 1 2 3</td>
<td></td>
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<tr>
<td>Dryness of skin and/or scalp             0 1 2 3</td>
<td></td>
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<tr>
<td>Mental sluggishness                      0 1 2 3</td>
<td></td>
</tr>
<tr>
<td><strong>Category XI</strong></td>
<td><strong>Category XVI (Menstruating Females Only)</strong></td>
</tr>
<tr>
<td>Heart palpitations                       0 1 2 3</td>
<td></td>
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<tr>
<td>Inward trembling                         0 1 2 3</td>
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<tr>
<td>Increased pulse even at rest             0 1 2 3</td>
<td></td>
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<tr>
<td>Nervous and emotional                    0 1 2 3</td>
<td></td>
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<tr>
<td>Insomnia                                 0 1 2 3</td>
<td></td>
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<tr>
<td>Night sweats                             0 1 2 3</td>
<td></td>
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<tr>
<td>Difficulty gaining weight                0 1 2 3</td>
<td></td>
</tr>
<tr>
<td><strong>Category XII</strong></td>
<td><strong>Category XV (Males only)</strong></td>
</tr>
<tr>
<td>Diminished sex drive                     0 1 2 3</td>
<td></td>
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<tr>
<td>Menstrual disorders or lack of menstruation 0 1 2 3</td>
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<tr>
<td>Increased ability to eat sugars without symptoms 0 1 2 3</td>
<td></td>
</tr>
<tr>
<td><strong>Category XIII</strong></td>
<td><strong>Category XVII (Menopausal Females Only)</strong></td>
</tr>
<tr>
<td>Increased sex drive                      0 1 2 3</td>
<td></td>
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<tr>
<td>Tolerance to sugary foods reduced       0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>“Splitting” type headaches               0 1 2 3</td>
<td></td>
</tr>
</tbody>
</table>

**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 fish?**

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

**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:**