

# 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.**

<b>Category I</b>					<b>Category V</b>				
Feeling that bowels do not empty completely	0	1	2	3	Greasy or high fat foods cause distress	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3	Lower bowel gas and or bloating				
Alternating constipation and diarrhea	0	1	2	3	several hours after eating	0	1	2	3
Diarrhea	0	1	2	3	Bitter metallic taste in mouth,				
Constipation	0	1	2	3	especially in the morning	0	1	2	3
Hard, dry, or small stool	0	1	2	3	Unexplained itchy skin	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3	Stool color alternates from clay colored				
More than 3 bowel movements daily	0	1	2	3	to normal brown	0	1	2	3
use laxatives frequently	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 II</b>					<b>Category VI</b>				
Excessive belching, burping, or bloating	0	1	2	3	Crave sweets during the day	0	1	2	3
Gas immediately following a meal	0	1	2	3	Irritable if meals are missed	0	1	2	3
Offensive breath	0	1	2	3	Depend on coffee to keep yourself going or started	0	1	2	3
Difficult bowel movements	0	1	2	3	Get lightheaded if meals are missed	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Eating relieves fatigue	0	1	2	3
Difficulty digesting fruits and vegetables;					Feel shaky, jittery, tremors	0	1	2	3
undigested foods found in stools	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 III</b>					<b>Category VII</b>				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3	Fatigue after meals	0	1	2	3
Do you frequently use antacids?	0	1	2	3	Crave sweets during the day	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Must have sweets after meals	0	1	2	3
Temporary relief from antacids, food,					Waist girth is equal or larger than hip girth	0	1	2	3
milk, carbonated beverages	0	1	2	3	Frequent urination	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	Increased thirst & appetite	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus,					Difficulty losing weight	0	1	2	3
peppers, alcohol, and caffeine	0	1	2	3					
<b>Category IV</b>					<b>Category VIII</b>				
Roughage and fiber cause constipation	0	1	2	3	Cannot stay asleep	0	1	2	3
Indigestion and fullness lasts 2-4					Crave salt	0	1	2	3
hours after eating	0	1	2	3	Slow starter in the morning	0	1	2	3
Pain, tenderness, soreness on left side					Afternoon fatigue	0	1	2	3
under rib cage	0	1	2	3	Dizziness when standing up quickly	0	1	2	3
Excessive passage of gas	0	1	2	3	Afternoon headaches	0	1	2	3
Nausea and/or vomiting	0	1	2	3	Headaches with exertion or stress	0	1	2	3
Stool undigested, foul smelling,					Weak nails	0	1	2	3
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					

*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**

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**

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**

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

**Category XVII**

How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental foggiess	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 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: \_\_\_\_\_

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:**