

## Metabolic Assessment Form

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

### PART I

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

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

### PART II

Please circle the appropriate number 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 relieved 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 or "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**

- Increasing frequency of food reactions 0 1 2 3
- Unpredictable food reactions 0 1 2 3
- Aches, pains, and swelling throughout body 0 1 2 3
- Unpredictable abdominal swelling 0 1 2 3
- Frequent bloating and distention after eating 0 1 2 3
- Abdominal intolerance to sugars and starches 0 1 2 3

#### **Category III**

- Intolerance to smells 0 1 2 3
- Intolerance to jewelry 0 1 2 3
- Intolerance to shampoo, lotion, detergents, etc. 0 1 2 3
- Multiple smell and chemical sensitivities 0 1 2 3
- Constant skin outbreaks 0 1 2 3

#### **Category IV**

- 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 food found in stools 0 1 2 3

#### **Category V**

- Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3
- Use of 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 by using antacids, food, milk, or 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 VI**

- Roughage and fiber cause constipation 0 1 2 3
- Indigestion and fullness last 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

#### **Category VII**

- Abdominal distention after consumption of fiber, starches, and sugar 0 1 2 3
- Abdominal distention after certain probiotic or natural supplements 0 1 2 3
- Lowered gastrointestinal motility, constipation 0 1 2 3
- Raised gastrointestinal motility, diarrhea 0 1 2 3
- Alternating constipation and diarrhea 0 1 2 3
- Suspicion of nutritional malabsorption 0 1 2 3
- Frequent use of antacid medication 0 1 2 3
- Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome? Yes No

#### **Category VIII**

- 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
- Burpy, fishy taste after consuming fish oils 0 1 2 3
- Difficulty losing weight 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 IX**

- Acne and unhealthy skin 0 1 2 3
- Excessive hair loss 0 1 2 3
- Overall sense of bloating 0 1 2 3
- Bodily swelling for no reason 0 1 2 3
- Hormone imbalances 0 1 2 3
- Weight gain 0 1 2 3
- Poor bowel function 0 1 2 3
- Excessively foul-smelling sweat 0 1 2 3

#### **Category X**

- Crave sweets during the day 0 1 2 3
- Irritable if meals are missed 0 1 2 3
- Depend on coffee to keep going/get started 0 1 2 3
- Get light-headed 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 XI**

- 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
- Difficulty losing weight 0 1 2 3

**Category XII**

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 XIII**

Cannot stay asleep	0 1 2 3
Perspire easily	0 1 2 3
Under a high amount 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 XIV**

Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

**Category XV**

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 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 hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

**Category XVI**

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

**Category XVI (Cont.)**

Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

**Category XVII (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 emptying	0 1 2 3
Leg twitching at night	0 1 2 3

**Category XVIII (Males Only)**

Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty 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
Decreased 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 XIX (Menstruating Females Only)**

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 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	
Pelvis pain during menses	0 1 2 3	
Irritable and depressed during menses	0 1 2 3	
Acne	0 1 2 3	
Facial hair growth	0 1 2 3	
Hair loss/thinning	0 1 2 3	

**Category XX (Menopausal Females Only)**

How many years have you been menopausal?	___	Years
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? \_\_\_\_\_

Rate your stress level on a scale from 1-10 during the average week: \_\_\_\_\_

How many caffeinated beverages do you consumer per day? \_\_\_\_\_

How many times do you eat fish per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times do you work out per week? \_\_\_\_\_

How many times do you eat raw nuts or seeds per week? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_

**Part IV**

Please list any medications you currently take and for what condition:

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