Metabolic Assessment Form

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

Part 1

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

1.
2.
3.
4.
5.

Part II

Please type in the appropriate number (0-3) on all questions below. '0' = least/never, '3' = most/always

Category I	**0 1 2 3**
Feeling that bowels do not empty completely	
Lower abdomen pain relief by passing stool/gas	
Alternating constipation and diarrhea	
Diarrhea	
Constipation	
Hard dry or small stool	
Coated tongue of "fuzzy" debris on tongue	
Pass large amount of foul smelling gas	
More than 3 bowel movements daily	
Use laxatives frequently	

Category II	**0 1 2 3**
Excessive belching, burping, or bloating	
Gas immediately following a meal	
Offensive breath	
Difficult bowel movements	
Sense of fullness during and after meals	
Difficulty digesting fruits and vegetables; undigested foods found in stools	

Category III	**0 1 2 3**
Stomach pain, burning or aching, 1-4 hrs after eating	
Frequently use antiacids	
Feeling hungry an hour or two after eating	
Heartburn when lying down or bending forward	
Temporary relief from antiacids, food, milk, carbonated beverages	
Digestive problems subside with rest and relaxation	
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	

Category IV	**0 1 2 3**
Roughage and fiber cause constipation	
Indigestion and fullness lasts 2-4 hours after eating	
Pain, tenderness, soreness on left side under rib cage bloated	
Excessive passage of gas	
Nausea and/or vomiting	
Stool is undigested, foul smelling, mucous-like, greasy, or poorly formed	
Frequent urination	
Increased thirst and appetite	
Difficulty losing weight	

Category V	**0 1 2 3**
Greasy or high fat foods cause distress	
Lower bowel gas and/or bloating several hours after eating	
Bitter metallic taste in mouth especially in the morning	
Unexplained itchy skin	
Yellowish cast to eyes	
Stool color alternates from clay-colored to normal brown	
Reddened skin especially palms	
Dry or flaky skin and/or hair	
History of gallbladder attacks/stones	
Have you had your gallbladder removed?	☐ Yes ☐ No

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Name: _____

Part 2 (continued)

Please type in the appropriate number (0-3) on all questions below. '0' = least/never, '3' = most/always

Category VI	**0 1 2 3**
Crave sweets during the day	
Irritable if meals are missed	
Depend on coffee to keep yourself going /started	
Get lightheaded if meals are skipped	
Eating relieves fatigue	
Feel shaky, jittery, or tremors	
Agitated, easily upset, or nervous	
Poor memory or forgetful	
Blurred Vision	

Category VII	**0 1 2 3**
Fatigue after meals	
Crave sweets during the day	
Eating sweets does not relieve cravings for sugar	
Must have sweets after meals	
Waist girth is equal or larger than hip girth	
Frequent urination	
Increased thirst or appetite	
Difficulty losing weight	

Category VIII	**0 1 2 3**
Cannot stay asleep	
Crave salt	
Slow starter in the morning	
Afternoon fatigue	
Dizziness when standing up quickly	
Afternoon headaches	
Headaches with exertion or stress	
Weak nails	

Category IX	**0 1 2 3**
Cannot fall asleep	
Perspire easily	
Under high amounts of stress	
Weight gain when under stress	

Category IX cont.	**0 1 2 3**
Wake up tired even after 6+ hours of sleep	
Excessive perspiration with little or no activity	

Category X	**0 1 2 3**
Tired, sluggish	
Feel cold (hands, all over, etc.)	
Require excess amounts of sleep to function properly	
Increase in weight-gain even with low-calorie diet	
Gain weight easily	
Difficult, infrequent bowel movements	
Depression, lack of motivation	
Morning headaches that wear off as the day progresses	
Outer third of eyebrows thins	
Thinning of hair on scalp, face, genitals, or excessive falling hair	
Dryness of skin and/or scalp	
Mental sluggishness	

Category XI	**0 1 2 3**
Heart palpitations	
Inward trembling	
Increased pulse even at rest	
Nervousness and emotional	
Insomnia	
Night sweats	
Difficulty gaining weight	

Category XII	**0 1 2 3**
Diminished sex drive	
Menstrual disorders of lack of menstruation	
Increased ability to eat sugars without symptoms	

Category XIII	**0 1 2 3**
Increased sex drive	
Tolerance to sugar reduced	
"Splitting" type headaches	

Metabolic Assessment Form

Name: _____

Part II (continued)

Please type in the appropriate number (0-3) on all questions below. '0' = least/never, '3' = most/always

Category XIV (Male Only)	**0 1 2 3**
Urination difficulty or dribbling	
Urination frequent	
Pain inside of legs or heels	
Feeling of incomplete bowel evacuation	
Leg nervousness at night	

Category XV (Male Only)	**0 1 2 3**
Decrease in libido	
Decrease in spontaneous morning erections	
Decrease in fullness of erections	
Difficulty maintaining morning erections	
Spells of mental fatigue	
Inability to concentrate	
Episodes of depression	
Muscle soreness	
Decrease in physical stamina	
Unexplained weight gain	
Increased in fat distribution around chest and hips	
Sweating attacks	
More emotional than in the past	

Category XVI (Menstruating Females Only)	**0 1 2 3**
In menopause	
Alternating menstrual cycle lengths	
Extended menstrual cycle, greater than 32 days	
Shortened menstrual cycle, less than every 24 days	
Pain and cramping during periods	
Scanty blood flow	
Heavy blood flow	
Breast pain and swelling during menses	
Pelvic pain during menses	
Irritable and depressed during menses	
Acne break outs	
Facial hair growth	
Hair loss/thining	

Category XVII (Menstruating Females Only)	**0 1 2 3**
How many years have you been menopausal?	_____
Have you had uterine bleeding since menopause?	☐ Yes ☐ No
Hot flashes	
Mental fogginess	
Disinterest in sex	
Mood swings	
Depression	
Painful intercourse	
Shrinking breast	
Facial hair growth	
Acne	
Increased vaginal pain, dryness, or itching	

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Name: _____

Part III

How many alcoholic beverages do you consume weekly?

How many caffeinated beverages do you consume weekly?

How many times do you eat raw nuts or seeds?

How many times do you eat fish weekly?

How many times do you eat out weekly?

Do you smoke? Yes ☐ or No ☐

If yes, how many times a day? , week?

Rate your stress level 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: