

# Metabolic Assessment Form

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

**Part 1:** please list the 5 major health concerns in your order of importance:

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

What is your health goal and how able are you to dedicate efforts towards your health?

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**Part 2:** Please circle the appropriate number to all questions below and then tally your score.

If you never experience the symptom, leave it blank. Rank the system in terms of frequency and severity with 1 being the lowest and 3 the highest. If you have a certain diagnosis, some of these will give you an automatic 5 points.

<b>Category I: GI</b>	<b>SCORE:</b>		
<b>Leaky Gut</b>			
Diagnosis of Celiac, Crohn's, Colitis or IBS (5 points)			5
Diarrhea	1	2	3
More than 3 bowel movements a day	1	2	3
Stools that are green or clay colored	1	2	3
Mucous on the stool	1	2	3
Bloating	1	2	3
Constipation	1	2	3
Hard, Dry, or small stool	1	2	3
Sense of Fullness with little food	1	2	3
Difficulty with fatty foods	1	2	3
GERD/Reflux	1	2	3
Belching, burping	1	2	3
Frequent use of antibiotics	1	2	3
Stomach Pain	1	2	3

<b>A. Dysbiosis/Candidiasis</b>	<b>SCORE:</b>		
Gas	1	2	3
Bloating with carbohydrates/sugar	1	2	3
Sugar Cravings	1	2	3
White Tongue	1	2	3
Worse with sugar or carbohydrates	1	2	3
Brain Fog	1	2	3
Foul Smelling Gas	1	2	3
Rectal Itching	1	2	3
Toe fungus, jock itch, athletes foot	1	2	3
Bad breath	1	2	3
Worse with vegetables/fruit/fiber	1	2	3

<b>Category II: Toxicity</b>	<b>SCORE:</b>		
Gallbladder removal			5
Sensitive to Smells	1	2	3
Can't have caffeine late in the day	1	2	3
Often have opposite reactions to medications and supplements	1	2	3
Use or around pesticides	1	2	3
Frequent dry cleaning	1	2	3
Leakage, wet carpets, or water damage	1	2	3
Feel better when I leave my home	1	2	3
Bitter metallic taste in the mouth	1	2	3
History of gallbladder attacks or stones	1	2	3
Itchy Skin	1	2	3
Reddened skin	1	2	3
Yellowish cast to eyes	1	2	3
Eat fish 3 or more times a week	1	2	3
Never sweat or sweat very easily	1	2	3

<b>Category III: Inflammation/Pain/Musculoskeletal</b>	<b>SCORE:</b>		
Fibromyalgia	1	2	3
Headaches/migraines (non-hormonal)	1	2	3
Joint Pain	1	2	3
Muscle Aches	1	2	3
Early morning stiffness	1	2	3
Swelling	1	2	3
Frequent use of NSAIDS	1	2	3
Decreased range of motion	1	2	3

<b>Category IV: Cognitive</b>	<b>SCORE:</b>		
Diagnosis of or feelings of: Depression, Anxiety, Cognitive Decline (5 points for one)			5
Poor memory	1	2	3
Poor concentration	1	2	3
Mood Swings	1	2	3

<b>Category V: Nervous System</b>	<b>SCORE:</b>		
Numbness	1	2	3
Tingling	1	2	3
Diminished Sensation of hot or cold	1	2	3
Loss of smell	1	2	3
Diminished hearing	1	2	3

<b>Category VI: Hormones (female)</b>	<b>SCORE:</b>		
<b>A. Menopause</b>			
Hot flashes	1	2	3
Brain fog	1	2	3
Insomnia	1	2	3
Osteopenia or Osteoporosis	1	2	3
Diminished quality of life	1	2	3
Change in voice	1	2	3
Change in skin	1	2	3
<b>B. Menstruation</b>			
<b>SCORE:</b>			
Diagnosis of Endometriosis, PCOS or Fibroids			5
Fertility issues	1	2	3
Cramps	1	2	3
Breast Tenderness	1	2	3
Cycles greater than 32 days or less than 24 days	1	2	3
Pain with period	1	2	3
Scanty or heavy blood flow	1	2	3
Irritability with period	1	2	3
Headaches with period	1	2	3
Acne	1	2	3
Facial hair growth	1	2	3
Hair loss or thinning	1	2	3

<b>Category VII: Hormones (male)</b>	<b>SCORE:</b>		
Poor libido	1	2	3
Erectile dysfunction	1	2	3
Fatigue	1	2	3
Irritability	1	2	3
Poor muscle mass	1	2	3
Weak Urine Flow	1	2	3

<b>Category VIII: Adrenal</b>	<b>SCORE:</b>		
Fatigue	1	2	3
Dizziness or lightheaded	1	2	3
Shaky or irritable when hungry	1	2	3
Sugar cravings	1	2	3
Salt cravings	1	2	3
Worse with exercise	1	2	3
Better with naps	1	2	3
Get a second wind at night	1	2	3
Wake feeling unrefreshed	1	2	3
Stress makes things worse	1	2	3
Difficulty sleeping at night	1	2	3
Use of steroids	1	2	3
Anxious	1	2	3
Headaches with Stress	1	2	3
Inward trembling	1	2	3
Can't get over things easily, easily stressed	1	2	3

<b>Category IX: Thyroid</b>	<b>SCORE:</b>		
Diagnosis of Hashimoto's or Graves (5 points)	1	2	3
Fatigue	1	2	3
Weight Gain	1	2	3
Constipation	1	2	3
Thin hair and/or breaking nails	1	2	3
Menstrual irregularities	1	2	3
Cold hands and feet	1	2	3
Feeling blue or depressed	1	2	3
Sleep excessively, 9 hours or more	1	2	3
Thinning eyebrows	1	2	3
No body hair	1	2	3
Dry skin	1	2	3
Mental sluggishness	1	2	3

<b>Category X: Cardiovascular</b>		<b>SCORE:</b>	
Diagnosis of High blood pressure or high cholesterol (5 points)			5
History of Stroke or TIAs			5
Chest tightness/Angina	1	2	3
Arrhythmia	1	2	3
Palpitations	1	2	3
Pulse higher than 80	1	2	3

<b>Category XI: Immune</b>		<b>SCORE:</b>	
Diagnosis of an Autoimmune Disease such as Lupus, RA, MS, Psoriasis, or another (5 points)			5
Low White Count	1	2	3
Takes more than 3-4 days to recover from a cold	1	2	3
Migratory pain	1	2	3
Lymph nodes that swell and remit	1	2	3
Periodic sweating (when not working out)	1	2	3
Fatigue that had a sudden onset	1	2	3
Frequent or recurrent infections	1	2	3
Frequent use of antibiotics	1	2	3

<b>Category XII: Allergies</b>		<b>SCORE:</b>	
Seasonal Issues	1	2	3
Sensitivities to foods	1	2	3
Hives	1	2	3
Headaches	1	2	3
Itching	1	2	3
Rashes	1	2	3
Eczema	1	2	3
Worse in moldy buildings	1	2	3
Shortness of Breath	1	2	3
Chest Tightness	1	2	3

Category XIII: Metabolic	SCORE:		
Diagnosis of Diabetes type II, Metabolic Syndrome or PCOS (5 points)	1	2	3
Weight gain	1	2	3
Frequent thirst and urination	1	2	3
Numbness or Tingling	1	2	3
Poor wound healing	1	2	3
Reoccurring yeast infections	1	2	3
Fatigue after meals	1	2	3
Crave sugar	1	2	3
Eat sugar daily	1	2	3
Gain weight around the middle	1	2	3
Gain weight easily even with minimal carbohydrate/sugar intake	1	2	3

### Part 3

How many alcoholic beverages do you consume per week? \_\_\_\_\_

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

List your three worst foods you eat during the average week:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how many times a day \_\_\_\_\_

Rate your level of stress from 1-10 during the average week \_\_\_\_\_

Current medications?

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Current Supplements?

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