

# Metabolic Assessment Form

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

**PART I: Please list your 5 major health concern in order of importance:**

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

**INSTRUCTIONS:** Please check mark the appropriate number "0-3" on all questions below. **0 as the least / never to 3 as the most / always**

<p><b>Category I</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 5%;">0</th> <th style="width: 5%;">1</th> <th style="width: 5%;">2</th> <th style="width: 5%;">3</th> </tr> </thead> <tbody> <tr><td>Feeling that bowels do not empty completely</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Lower abdominal pain relieved by passing stool or gas</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Alternating constipation and diarrhea</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Diarrhea</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Constipation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hard, dry or small stool</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Coated tongue of "fuzzy" debris on tongue</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pass large amounts of foul smelling gas</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>More than 3 bowel movements daily</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Use of laxatives</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><b>Category II</b></p> <table style="width: 100%; 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undigested foods found in stools</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><b>Category III</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 5%;">0</th> <th style="width: 5%;">1</th> <th style="width: 5%;">2</th> <th style="width: 5%;">3</th> </tr> </thead> <tbody> <tr><td>Stomach pain, burning or aching 1-4 hours after eating</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Use of antacids</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hungry an hour or two after eating</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Heartburn when lying down or bending forward</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Temporary relief from antacids, food, milk, carbonated beverages</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Digestive problems subside with rest and relaxation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><b>Category IV</b></p> <table style="width: 100%; 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type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Feel shaky, jittery, or have tremors</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Agitated, easily upset, nervous</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Poor memory, forgetful</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Blurred vision</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><b>Category VII</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 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<tr><td>Crave salt</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Slow starter in the morning</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Afternoon fatigue</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Dizziness when standing up quickly</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Afternoon headaches</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Headaches with exertion or stress</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Weak nails</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><b>Category IX</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 5%;">0</th> <th style="width: 5%;">1</th> <th style="width: 5%;">2</th> <th style="width: 5%;">3</th> </tr> </thead> <tbody> <tr><td>Cannot fall asleep</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Perspire easily</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Under high amounts of stress</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Weight gain when under stress</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Wake up tired even after 6 or more hours of sleep</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Excessive perspiration or perspiration with little or no activity</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><b>Category X</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 5%;">0</th> <th style="width: 5%;">1</th> <th style="width: 5%;">2</th> <th style="width: 5%;">3</th> </tr> </thead> <tbody> <tr><td>Tired, sluggish</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Feel cold – hands, feet, all over</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Require excessive amounts of sleep to function properly</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Increase in weight even with low-calorie diet</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Gain weight easily</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Difficult, infrequent bowel movements</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Depression, lack of motivation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Morning headaches that wear off as the day progresses</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Outer third of eyebrow thins</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Thinning of hair on scalp, face or genitals / hair loss</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Dryness of skin and/or scalp</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Mental sluggishness</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><b>Category XI</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 5%;">0</th> <th style="width: 5%;">1</th> <th style="width: 5%;">2</th> <th style="width: 5%;">3</th> </tr> </thead> <tbody> <tr><td>Heart palpitations</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Inward trembling</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Increased pulse even at rest</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Nervous and emotional</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Insomnia or night-sweats</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		0	1	2	3	Get lightheaded if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating relieves fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel shaky, jittery, or have tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agitated, easily upset, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor memory, forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		0	1	2	3	Fatigue after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating sweets does not relieve cravings for sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Must have sweets after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased thirst & appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Waist girth is equal to or larger than hip girth	Yes <input type="checkbox"/>	No <input type="checkbox"/>				0	1	2	3	Cannot stay asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow starter in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Afternoon fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness when standing up quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Afternoon headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches with exertion or stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weak nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		0	1	2	3	Cannot fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perspire easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Under high amounts of stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain when under stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wake up tired even after 6 or more hours of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive perspiration or perspiration with little or no activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		0	1	2	3	Tired, sluggish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel cold – hands, feet, all over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Require excessive amounts of sleep to function properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increase in weight even with low-calorie diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gain weight easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult, infrequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression, lack of motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning headaches that wear off as the day progresses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outer third of eyebrow thins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thinning of hair on scalp, face or genitals / hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness of skin and/or scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental sluggishness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		0	1	2	3	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inward trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased pulse even at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous and emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia or night-sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Feeling that bowels do not empty completely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Lower abdominal pain relieved by passing stool or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Alternating constipation and diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Hard, dry or small stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Coated tongue of "fuzzy" debris on tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Pass large amounts of foul smelling gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
More than 3 bowel movements daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Use of laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Excessive belching, burping or bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Gas immediately following a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Offensive breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Difficult bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Sense of fullness during and after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Difficulty digesting fruits and vegetables; undigested foods found in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Stomach pain, burning or aching 1-4 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Use of antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Hungry an hour or two after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Heartburn when lying down or bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Temporary relief from antacids, food, milk, carbonated beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Digestive problems subside with rest and relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Roughage and fiber cause constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Indigestion and fullness lasts 2-4 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Pain, tenderness, bloating on left side under rib cage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Excessive passage of gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Stool foul smelling, mucous-like, greasy or poorly formed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Increased thirst and appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Greasy or high-fat foods cause distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Lower bowel gas or bloating hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Bitter metallic taste in mouth, especially in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Unexplained itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Yellowish cast to eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Stool color alternates for clay colored to normal brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Reddened skin, especially palms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Dry or flaky skin and/or hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
History of gallbladder attacks or stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Have you had your gallbladder removed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
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Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Irritable if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Depend on caffeine to keep yourself going or started	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Get lightheaded if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Eating relieves fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Feel shaky, jittery, or have tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Agitated, easily upset, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Poor memory, forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Fatigue after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Eating sweets does not relieve cravings for sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Must have sweets after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Increased thirst & appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Waist girth is equal to or larger than hip girth	Yes <input type="checkbox"/>	No <input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
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Cannot stay asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Crave salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Slow starter in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Afternoon fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Dizziness when standing up quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Afternoon headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Headaches with exertion or stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Weak nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Cannot fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Perspire easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Under high amounts of stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Weight gain when under stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Wake up tired even after 6 or more hours of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Excessive perspiration or perspiration with little or no activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Tired, sluggish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Feel cold – hands, feet, all over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Require excessive amounts of sleep to function properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Increase in weight even with low-calorie diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Gain weight easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Difficult, infrequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Depression, lack of motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Morning headaches that wear off as the day progresses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Outer third of eyebrow thins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Thinning of hair on scalp, face or genitals / hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Dryness of skin and/or scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Mental sluggishness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Inward trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Increased pulse even at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Nervous and emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
Insomnia or night-sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											

**Category XII**

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

**Category XIII**

Increased sex drive  0  1  2  3  
 Eating sugars causes distress / symptoms       
 "Splitting" type headaches

**Category XIV (Male Only)**

Urination difficulty or dribbling  0  1  2  3  
 Frequent urination       
 Pain inside of legs or heels       
 Feeling of incomplete bowel evacuation       
 Leg nervousness at night

**Category XV (Males Only)**

Decrease in libido  0  1  2  3  
 Decrease in spontaneous morning erections       
 Decrease in fullness of erections       
 Difficulty in maintain morning erections       
 Spells of mental fatigue       
 Inability to concentrate       
 Episodes of depression       
 Muscle soreness       
 Decrease in physical stamina       
 Unexplained weight gain       
 Increase in fat distribution around chest and hips       
 Sweating attacks       
 More emotional than in the past

**Category XVI (Menstruating Females Only)**

Are you peri-menopausal? 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

**0 1 2 3**  
 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/thinning

**Category XVII (Menopausal Females only)**

How many years have you been menopausal?  
 Have you ever had uterine bleeding since menopause? Yes  No

**0 1 2 3**  
 Hot flashes      
 Mental foginess      
 Disinterest in sex      
 Mood swings      
 Depression      
 Painful intercourse      
 Shrinking breasts      
 Facial hair growth      
 Acne      
 Increased vaginal pain, dryness or itching

**Category - S**

Feel you are losing your pleasure / enthusiasm for hobbies, interests, activities?  0  1  2  3  
 Feel overwhelmed with ideas to manage?       
 Feelings of inner rage (anger)?       
 Feelings of paranoia?       
 Feel sad or down for no reason?       
 Feel like you are not enjoying life?       
 Feel you lack artistic appreciation?       
 Feel depressed in overcast weather?       
 Feel you are losing enjoyment for your favorite foods?

**Category S - (continued)**

Feel you are losing your enjoyment of friendships / relationships?  0  1  2  3  
 Feel you have difficulty falling into deep restful sleep?       
 Feelings of dependency on others?       
 Feel you are more susceptible to pain?       
 Feelings of unprovoked anger?       
 Feel you are losing interest in life?

**Category D**

Experience feelings of hopelessness?  0  1  2  3  
 Experience self-destructive thoughts?       
 Feel you have an inability to handle stress?       
 Feelings of anger and aggression while under stress?       
 Feel you are not rested even after long hours of sleep?       
 Prefer to isolate yourself from others?       
 Feel unexplained lack of concern for family / friends?       
 Feel distracted from your tasks?       
 Experience an inability to finish tasks?       
 Feel the need to consume caffeine to stay alert?       
 Feel you lose your temper for minor reasons?       
 Experience feelings of worthlessness?

**Category G**

Feelings of anxiety or panic for no reason?  0  1  2  3  
 Feelings of dread or impending doom?       
 Experience the feeling of knots in your stomach?       
 Feelings of being overwhelmed for no reason?       
 Feelings of guilt about everyday decisions?       
 Experience that your mind feel restless?       
 Difficulty turning your mind off when you want to relax?       
 Experience disorganized attention?       
 Experience feelings of worry about things you were not worried about before?       
 Feelings of inner tension and / or inner excitability?

**Category A**

Feel your visual memory (shapes & images) is decreased?  0  1  2  3  
 Feel your verbal memory is decreased?       
 Experience memory lapses?       
 Feel your creativity been decreased?       
 Feel your comprehension been diminished?       
 Feel you have difficulty calculating numbers?       
 Feel you have difficulty recognizing objects & faces?       
 Feel like your opinion about yourself has changed?       
 Feel you are experiencing slower mental responses?

**Other**

Have you ever smoked?  Y  N If yes, for how long? \_\_\_\_\_  
 Have you been exposed to prolonged periods of second hand smoke?  Y  N  
 Do you have mercury amalgam fillings?  Y  N  
 Have you ever worked with chemicals for a prolonged period of time?  Y  N  
 Have you ever lived near a farm, or industrial area?  Y  N  
 Do you have any artificial joints or implants or pacemaker?  Y  N

How are things in the following areas?

	Good	Fair	Poor	NA
Job / School				
Social Life				
Spiritual Life				
Close friends				
Spouse / Partner				
Children				
Parents				