

**Metabolic Assessment**

Please circle the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always

**Category I:**

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

**Category II:**

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

**Category III:**

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

**Category IV:**

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

**Category V:**

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

**Category VI:**

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

**Category VII:**

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

**Category VIII:**

Cannot stay asleep 0 1 2 3  
 Crave salt 0 1 2 3  
 Slow starter in morning 0 1 2 3  
 Afternoon fatigue 0 1 2 3  
 Dizziness when standing up too early 0 1 2 3  
 Afternoon headaches 0 1 2 3  
 Headaches with exertion or stress 0 1 2 3  
 Weak nails 0 1 2 3

**Category IX:**

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

**Category X:**

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

**Category XI:**

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

**Category XII: Pituitary Hypofunction**

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

**Category XIII: Pituitary Hyperfunction**

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

**Category XIV: Prostate (Male only)**

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

**Category XV: Andropause (Male only)**

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

**Category XVI: (Menstruating females only)**

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Do you take the oral contraceptive pill	Yes	No		
Have you in the past	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

**Category XVII: (Menopausal Females only)**

How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?	Yes	No		
Do you take hormone replacement therapy	Yes	No		
Have you in the past	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3