Metabolic Screening Questionnaire

Name_____ **Date**_____

Rate each of the following symptoms based upon your health in the past 30 days:

0 – Never or almost never have the symptoms
1 – Occasionally have it, effect is not severe (I do not like the symptom.)
2 – Occasionally have it, effect is severe (I <u>really</u> do not like the symptom.)
3 – Frequently have it, effect is not severe (I do not like the symptom.)
4 – Frequently have it, effect is severe (I <u>really</u> do not like the symptom.)

Add the numbers for each section, and then add the totals for each section to arrive at the grand total.

DIGESTIVE

__ Nausea or vomiting
__ Diarrhea
__ Constipation
__ Bloated feeling
__ Belching, passing gas
__ Heartburn
__ TOTAL

EMOTIONS

__ Mood swings
__ Anxiety, fear, nervous
__ Anger, irritability
__ Depression
__ TOTAL

EYES

__Watery, itchy eyes
__ Swollen, reddened or sticky eyelids
__ Dark circles under eyes
__ Blurred/tunnel vision
__ TOTAL

LUNGS

__Chest congestion
__ Asthma, bronchitis
__ Shortness of breath
__ Difficulty breathing
__ TOTAL

EARS

__ Itchy ears
__ Earaches, ear infection
__ Drainage from ear
__ Ringing in ears, hearing loss
__ TOTAL

ENERGY/ACTIVITY

__ Fatigue, sluggishness
__ Apathy, sluggishness
__ Hyperactivity
__ Restlessness
__ TOTAL

HEAD

__ Headaches
__ Faintness
__ Dizziness
__ Insomnia
__ TOTAL

MIND

Poor memory
__ Confusion
__Poor concentration
__ Poor coordination
__ Difficulty making decisions
__ Stuttering, stammering
__ Slurred speech
__ Learning disabilities
__ TOTAL

MOUTH/THROAT

__Chronic coughing
__ Gagging, need to clear throat
__ Sore throat, hoarse
__ Swollen or discolored tongue, gums, lips
__ Canker sores
__ TOTAL

SKIN

__ Acne
__ Hives, rashes, dry skin
__ Hair loss
__Flushing or hot flashes
__ Excessive sweating.
__Total

JOINT/MUSCLES

__ Pain or aches in joints
__ Arthritis
__ Stiff, limited movement
__ Pain, aches in muscles
__ Weakness or tiredness
__ TOTAL

NOSE

__ Stuffy nose
__ Sinus problems
__ Hay fever
__ Sneezing attacks
__ Excessive mucus
__ TOTAL

HEART

__Skipped heartbeats
__ Rapid heartbeats
__ Chest pain
__ TOTAL

WEIGHT

__ Binge eating/drinking
__Craving certain foods
__ Excessive weight gain
__Compulsive eating
__ Water retention
__ Underweight
__ TOTAL

OTHER

__ Frequent illness
__ Frequent/urgent urination
__ Genital itch, discharge
__ TOTAL

GRAND TOTAL____