Metabolic Assessment Form

BETTER BODY WELLNESS - NUTRITION, ACUPUNCTURE & CHINESE MEDICINE

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

Address: _____ Blood Type ___ Secretor Status: S / NS

Phone Number: Home (____) _____ Office (____) _____ Cell (____) _____

How do you currently grade your health?

On a scale of 1-10 with 1 being the worst you have ever been and 10 being the best you have ever been or would like to be.

1 2 3 4 5 6 7 8 9 10

PART I

Please list the 5 major health concerns in your order of importance: (include any diagnosis)

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

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

					NOTES
Category I (Lewis)					
Are you prone to yeast infections (oral, intestinal, vaginal)?	**Yes**			**No**	
Are you prone to bladder (urinary tract) infections?	**Yes**			**No**	
Do you or your family have a history of alcoholism	**Yes**			**No**	
Have you ever been diagnosed with mitral valve prolapse?	**Yes**			**No**	
Do you have a heart murmur?	**Yes**			**No**	
Are you prone to cavities, gum disease, excessive tartar buildup?	**Yes**			**No**	
Do you have any root canals in your mouth?	**Yes**			**No**	
Do you have arthritic tendencies?	**Yes**			**No**	
Category II (Hypo-Chlor)					
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 stools	**0**	**1**	**2**	**3**	
Category III (Hyper-Ac)					
Stomach pain, burning or aching 1-4 hours after eating	**0**	**1**	**2**	**3**	
Use of antacids	**0**	**1**	**2**	**3**	
Feeling hungry an hour or two after eating	**0**	**1**	**2**	**3**	
Heartburn especially 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**	
Category IV (Int.)					
Feeling that bowels do not completely empty	**0**	**1**	**2**	**3**	
Diarrhea	**0**	**1**	**2**	**3**	
Constipation	**0**	**1**	**2**	**3**	
Hard, dry or small stool	**0**	**1**	**2**	**3**	
Excessive passage of gas	**0**	**1**	**2**	**3**	
Intestinal pain (irritable bowel or colitis)	**0**	**1**	**2**	**3**	
Coated tongue – fuzzy debris on tongue	**0**	**1**	**2**	**3**	
Use of laxatives	**0**	**1**	**2**	**3**	

PART II *"continues"*

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

Category V (Bili)				
Headache over eyes	**0**	**1**	**2**	**3**
Greasy or high fat foods cause distress	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes - "whites" of eyes (sclera)	**0**	**1**	**2**	**3**
Stool color is light brown or yellow	**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	**0**	**1**	**2**	**3**
Feet burn / itch / skin peels on feet	**0**	**1**	**2**	**3**
Dry, cracked skin on edge of heels	**0**	**1**	**2**	**3**
Category VI (Hypo-Gly)				
Crave sweets during the day	**0**	**1**	**2**	**3**
Depend on caffeine to get started or keep going	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, irritable or "light-headed" if meals are delayed	**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 (Ins-Res)				
Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day or after meals	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**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 (Hypo-Adr)				
Heal slowly	**0**	**1**	**2**	**3**
Prone to respiratory disorders like bronchitis, asthma	**0**	**1**	**2**	**3**
Swollen ankles (worse at night)	**0**	**1**	**2**	**3**
Blood pressure low	**0**	**1**	**2**	**3**
Allergies (hayfever - like) / hives	**0**	**1**	**2**	**3**
Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue, yawn often	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**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 (Hyper-Adr)				
Cannot fall asleep	**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 7 or more hours of sleep	**0**	**1**	**2**	**3**
Excessive perspiration or perspiration with little or no activity	**0**	**1**	**2**	**3**
Blood pressure increased	**0**	**1**	**2**	**3**

NOTES

PART II "*continues*"

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

Category X (Hypo-Thy)				
Tired, sluggish, mentally sluggish	**0**	**1**	**2**	**3**
Feeling cold – hands, feet, all over	**0**	**1**	**2**	**3**
Require much sleep to function well	**0**	**1**	**2**	**3**
Gain weight easily	**0**	**1**	**2**	**3**
Difficulty, infrequent bowel movements	**0**	**1**	**2**	**3**
Depression, lack of motivation	**0**	**1**	**2**	**3**
Morning headaches that wear off as the 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 hair	**0**	**1**	**2**	**3**
Dryness of skin and/or scalp	**0**	**1**	**2**	**3**
Category XI (Hyper Thy)				
Heart palpations	**0**	**1**	**2**	**3**
Increased pulse even at rest	**0**	**1**	**2**	**3**
Nervous, emotional / inward trembling	**0**	**1**	**2**	**3**
Insomnia	**0**	**1**	**2**	**3**
Night sweats	**0**	**1**	**2**	**3**
Difficulty gaining weight	**0**	**1**	**2**	**3**
Category XII (Pros) (Males 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 XIII (Menstruating Females Only)				
Are you perimenopausal	**0**	**1**	**2**	**3**
Alternating menstrual cycle lengths	**0**	**1**	**2**	**3**
Extended menstrual cycle, greater than 32 days	**0**	**1**	**2**	**3**
Shortened menses, less than every 24 days	**0**	**1**	**2**	**3**
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**
Irritable and depressed during menses	**0**	**1**	**2**	**3**
Acne break-outs	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Category XIV (Menopausal Females Only)				
How many years have you been menopausal	**0**	**1**	**2**	**3**
Do you ever have uterine bleeding since menopause?	**0**	**1**	**2**	**3**
Hot flashes	**0**	**1**	**2**	**3**
Mental fogginess	**0**	**1**	**2**	**3**
Disinterest in sex	**0**	**1**	**2**	**3**
Depression / Mood swings	**0**	**1**	**2**	**3**
Painful intercourse / Vaginal dryness	**0**	**1**	**2**	**3**
Shrinking breasts	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Acne break-outs	**0**	**1**	**2**	**3**

NOTES

PART II "*continues*"

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

Numbness in hands and feet (extremities go to "sleep")	**0**	**1**	**2**	**3**
Intolerant to MSG	**0**	**1**	**2**	**3**
Cannot recall dreams	**0**	**1**	**2**	**3**
Frequent nose bleeds	**0**	**1**	**2**	**3**
Bruise easily ("black and blue" spots)	**0**	**1**	**2**	**3**
Muscle – legs and toes cramping at rest or sleep	**0**	**1**	**2**	**3**
Crave chocolate	**0**	**1**	**2**	**3**
Feet have bad odor	**0**	**1**	**2**	**3**
Frequent hoarseness	**0**	**1**	**2**	**3**
Difficulty swallowing	**0**	**1**	**2**	**3**
Dry mouth – eyes – nose	**0**	**1**	**2**	**3**
White spots on fingernails	**0**	**1**	**2**	**3**
Reduced or "lost" sense of taste/smell	**0**	**1**	**2**	**3**
Ringing in ears	**0**	**1**	**2**	**3**
Sensitive to bright lights	**0**	**1**	**2**	**3**
Vulnerable to insect bites (fleas, mosquitoes)	**0**	**1**	**2**	**3**

NOTES

PART III

1. Do you smoke? Y / N If yes, how often? _____
2. How much alcohol do you consume weekly? _____
3. How much coffee (or caffeinated beverages) do you consume daily? _____
4. Have you had any surgeries? _____
5. How often do you exercise? _____
6. Do you skip meals? _____
7. How many hours per night do you sleep? _____
8. Please list any medications you currently take and for what conditions: _____

_____

_____

9. Please list any natural supplements you currently take: _____

_____

_____

10. Additional comments: _____

_____

_____

_____

Information obtained from this assessment form is for educational purposes only. It is strictly confidential and not intended to diagnose, treat, cure, or prevent any disease. This information should be considered adjunctive to other acceptive procedures deemed necessary by the client's own attending licensed physician.

Client Signature: _____ *Date:* _____