Metabolic Assessment Form

Name:____ Age:__________ Sex:__________ Date: _______

Part I

Please list your 3 major health concerns in order of importance 1.
2.
3.

Medication List

Medications (include over the counter and herbal medications)	Dose (strength, # of pills/drops)	Route (by mouth, inhaled, topical)	Frequency (how often)
1.			
2.			
3.			
4.			
5.			

Part II (Please circle the appropriate number "0 - 3" on all questions below. 0 = never, 1 = occasionally, 2 = somewhat frequently, 3 = very frequently)

Category I: Colon					Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Feeling that bowels do not empty completely	0	1	2	3	Do you frequently used antacids	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3	Feeling hungry an hour or two after eating	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Heartburn when lying down or bending forward	0	1	2	3
Diarrhea	0	1	2	3	Temporary relief from antacids, food, milk, or carbonated beverages	0	1	2	3
Constipation	0	1	2	3	Digestive problems subside with rest and relaxation	0	1	2	3
Hard dry or small stool	0	1	2	3	Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, or caffeine	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3	**Category IV: Small Intestine (Pancreas)**				
Pass large amount of foul smelling gas	0	1	2	3	Roughage and fiber cause constipation	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Do you use laxatives frequently	0	1	2	3	Pain, tenderness, soreness on left side under rib cage (bloated feeling)	0	1	2	3
Category II: Hypochlorydia					Excessive passage of gas	0	1	2	3
Excessive belching, burping, or bloating	0	1	2	3	Nausea and/or vomiting	0	1	2	3
Gas immediately following a meal	0	1	2	3	Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3
Offensive breath	0	1	2	3	Frequent urination	0	1	2	3
Difficult bowel movements	0	1	2	3	Infrequent urination	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Blood in urine	0	1	2	3
Difficulty digesting fruits and vegetables	0	1	2	3	Painful urination	0	1	2	3
Undigested foods found in stool	0	1	2	3	Increased thirst and appetite	0	1	2	3
Category III: Hyperacidity (Ulcer)					Difficulty losing weight	0	1	2	3

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Category V: Biliary Insufficiency/Statis					Blurred vision	0	1	2	3
Greasy or high fat foods cause distress	0	1	2	3	**Category VII: Insulin Resistance**				
Lower bowel gas and or bloating several hours after eating	0	1	2	3	Fatigue after meals	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3	Crave sweets during the day	0	1	2	3
Unexplained itchy skin	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Yellowish cast to eyes	0	1	2	3	Must have sweets after meals	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3	Waist girth is equal or larger than hip girth	Yes		No	
Reddened skin, especially palms	0	1	2	3	Frequent urination	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3	Increased thirst and appetite	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3	Difficulty losing weight	0	1	2	3
Have you had your gallbladder removed	Yes		No		**Category VIII: Adrenal Hypofunction**				
Category VI: Hypoglycemia					Cannot stay sleep	0	1	2	3
Crave sweets during the day	0	1	2	3	Crave salt	0	1	2	3
Irritable if meals are missed	0	1	2	3	Slow starter in the morning	0	1	2	3
Depending on coffee to keep yourself going or started	0	1	2	3	Afternoon fatigue	0	1	2	3
Get lightheaded and if meals are missed	0	1	2	3	Dizziness when standing up quickly	0	1	2	3
Eating relieves fatigue	0	1	2	3	Afternoon headaches	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3	Headaches with exertion or stress	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3	Weak nails	0	1	2	3
Poor memory, forgetful	0	1	2	3	Change in nail	0	1	2	3
IX: Adrenal Hyperfunction					**Category X: Hypothyroid**				
Cannot fall asleep	0	1	2	3	Tired, sluggish	0	1	2	3
Perspire easily	0	1	2	3	Feel cold – hands, feet, all over	0	1	2	3
Under high amounts of stress	0	1	2	3	Require excessive amounts of sleep to function properly	0	1	2	3
Weight gain when under stress	0	1	2	3	Increase in weight gain even with low-calorie diet	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3	Gain weight easily	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3	Difficult, infrequent bowel movements	0	1	2	3
Category XI: Thyroid Hyperfunction					Depression, lack of motivation	0	1	2	3
Heart palpitation	0	1	2	3	Morning headaches that wear off as the day progresses	0	1	2	3
Inward trembling	0	1	2	3	Outer third of eyebrows thin	0	1	2	3
Increased pulse, even at rest	0	1	2	3	Thinning of hair on scalp, face, or genitals	0	1	2	3
Nervous and emotional	0	1	2	3	Excessive falling hair	0	1	2	3
Insomnia	0	1	2	3	Dryness of skin	0	1	2	3
Night sweats	0	1	2	3	Dryness of scalp	0	1	2	3
Difficulty gaining weight	0	1	2	3	Mental sluggishness	0	1	2	3
Category XII: Pituitary Hypofunction					**Category XIII: Pituitary Hyperfunction**				
Diminished sex drive	0	1	2	3	Increased sex drive	0	1	2	3

Menstrual disorders or lack of menstruation	0	1	2	3	Tolerance to sugars reduced	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3	"Splitting" type headache	0	1	2	3
Category XIV (Male Only):					**Category XV (Female Only):**				
Urination difficulty or dribbling	0	1	2	3	Are you perimenopausal	Yes		No	
Urination frequent	0	1	2	3	Alternating menstrual cycle lengths	Yes		No	
Pain inside of legs or heels	0	1	2	3	Extended menstrual cycle, greater than 32 days	Yes		No	
Feeling of incomplete bowel evacuation	0	1	2	3	Shortened menses, less than every 24 days	Yes		No	
Leg nervousness at night	0	1	2	3	Pain and cramping during periods	0	1	2	3
Decrease in libido	0	1	2	3	Scanty blood flow	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3	Heavy blood flow	0	1	2	3
Decrease in fullness of erections	0	1	2	3	Breast pain and swelling during menses	0	1	2	3
Spells of mental fatigue	0	1	2	3	Irritable and depressed menses	0	1	2	3
Inability to concentrate	0	1	2	3	Acne break outs	0	1	2	3
Episodes of depression	0	1	2	3	Facial hair growth	0	1	2	3
Muscle soreness	0	1	2	3	Hair loss/thinning	0	1	2	3
Decrease in physical stamina	0	1	2	3	Date of last menstrual period				
Unexplained weight gain	0	1	2	3	Date of last Pap				
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					

Patient Authorization:

Thank you for taking the time to fill out this health history questionnaire. This information is important to the doctor obtaining an accurate clinical picture so as to make an appropriate diagnosis and treatment plan. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at NeuroSport Elite.

Any disclosure is outlined in our privacy policies.

Patient (or guardian) signature:______________________________ Date:_______________________

Printed name:____

Signature of translator or person assisting you:_______________________ Date:________________