

Name:

DOB :

**Metabolic Screening Questionnaire**

Rate each of the following symptoms based upon your health profile for the past 30 days.

**POINT SCALE**

- 0 = Never or almost never have the symptom  
 1 = Occasionally have it, effect is not severe  
 2 = Occasionally have it, effect is severe  
 3 = Frequently have it, effect is not severe  
 4 = Frequently have it, effect is severe

<b>DIGESTIVE TRACT</b>	___	Nausea or vomiting	<b>Total</b>
	___	Diarrhea	
	___	Constipation	
	___	Bloated Feeling	
	___	Belching, or passing gas	
	___	Heartburn	
	___	Intestinal/Stomach Pain	___
<b>EARS</b>	___	Itchy Ears	<b>Total</b>
	___	Earaches, ear infections	
	___	Drainage from ear	
	___	Ringing in ears, hearing loss	
<b>EMOTIONS</b>	___	Mood swings	<b>Total</b>
	___	Anxiety, fear or nervousness	
	___	Anger, irritability, or aggressiveness	
	___	Depression	___
<b>ENERGY/ACTIVITY</b>	___	Fatigue, sluggishness	<b>Total</b>
	___	Apathy, lethargy	
	___	Hyperactivity	
	___	Restlessness	___
<b>EYES</b>	___	Watery or itchy eyes	<b>Total</b>
	___	Swollen, reddened or sticky eyelids	
	___	Bags or dark circles under eyes	
	___	Blurred or tunnel vision (does not include near- or far-sightedness)	___
<b>HEAD</b>	___	Headaches	<b>Total</b>
	___	Faintness	
	___	Dizziness	
	___	Insomnia	___
<b>HEART</b>	___	Irregular or skipped heartbeat	<b>Total</b>
	___	Rapid or pounding heartbeat	
	___	Chest pain	___
<b>JOINTS/MUSCLES</b>	___	Pain or aches in joints	<b>Total</b>
	___	Arthritis	
	___	Stiffness or limitation of movement	
	___	Pain or aches in muscles	
	___	Feeling of weakness or tiredness	___