Metabolic Assessment Form

Lynch Chiropractic and Chronic Pain Solutions

Name: Age: Sex: Date:

Please list the 5 major health concerns in your order of importance:

1.
2.
3.
4.
5.

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	0 1 2 3
Alternating constipation 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 & after meals	0 1 2 3
Difficulty digesting fruits & vegetables	0 1 2 3
Undigested food found in stools	0 1 2 3
Category III	
Stomach burning/aching 1-4 hours after eating	0 1 2 3
Do you frequently use antacids?	0 1 2 3
Feeling hungry 1-2 hours after eating	0 1 2 3
Heartburn when lying down or bending	0 1 2 3
Temporary relief from antacids, food, milk,	
Carbonated beverages	0 1 2 3
Digestive problems subside with rest	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/fullness lasts 2-4 hours after meal	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 & appetite	0 1 2 3
Difficulty losing weight	0 1 2 3
Category V	
Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating after eating	0 1 2 3
Bitter metallic taste in mouth	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates in color	0 1 2 3
Reddened skin, especially in palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks/stones	0 1 2 3
Gallbladder removed?	0 1 2 3
Category VI	
Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to get going/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, agitated, 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
Eating sweets does not relieve craving	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 the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches w/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 after 6 or more hours of sleep	0 1 2 3
Excessive perspiration with little to 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 amount of sleep to function	0 1 2 3
Increase in weight gain even w/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
AM headaches wear off as day progresses	0 1 2 3
Outer third of eyebrow thinning	0 1 2 3
Thinning of hair on scalp, face or genitals	0 1 2 3
Excessive loss 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 palpations	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	
Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars w/o symptoms	0 1 2 3
Category XIII	
Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
"Splitting" type headaches	0 1 2 3
Category XIV (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 XV (Males 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/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
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?	_______
Since Menopause, do you ever have bleeding?	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

How many caffeinated beverages do you consume a day? _____________

How many times a week do you eat raw nuts or seeds? ___________

How many times a week do you work out? _________

How many alcoholic beverages do you consume a week? ____________

How many times do you eat out per week? _________

How many times a week do you eat fish? _________

List the three worst foods you eat during the week on average _____________ _____________ ____________

List the three healthiest foods you eat during the week
on average ___________ ___________ __________

Do you smoke? Yes/No
If yes to above, how many times a day? ___________

Rate your stress levels on a scale of 1-10 on an
average week:__________________

Please list any medications you currently take and for
what conditions:
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Please list any natural supplements you currently take
and for what conditions:
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