DFW Holistic Health
Metabolic Assessment Form

Name: Age: Height: Weight: Date:

List your five major health concerns, in order of importance: Then, circle the appropriate number on all questions below.

1)
2)
3)
4)
5)

0 = None / Never **1 = Mild / Occasionally** **2 = Moderate / Frequently** **3 = Severe / Constant**

Stomach / ↓HCL

Uncomfortable bloating/fullness in stomach, or upper abdomen up to 1 hour after eating	0	1	2	3
Belching or burping	0	1	2	3
Use of antacids -- Current☐ Past☐ Years_____	0	1	2	3
History of ulcer, gastritis	Yes		No	
Use of aspirin/anti-inflammatories -- Current☐ Past☐	0	1	2	3
Heartburn or indigestion	0	1	2	3
Offensive or sour breath	0	1	2	3

SI/Absorpt/Gut

Bloating 1-3 hours after eating	0	1	2	3
Food reactions or intolerances	0	1	2	3
Abdominal cramping or pain	0	1	2	3
Excema / psoriasis / skin rashes	0	1	2	3
Undigested food in stool (other than corn)	0	1	2	3

LI/Elimination

Feeling that bowels do not completely empty	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Use of laxatives -- Current☐ Past☐ Years_____	0	1	2	3
Foul smelling gas	0	1	2	3
Mucus, blood, or black tarry in stool (circle which)	0	1	2	3
Average number of BM per day ______ or per week _________				

Liver/Detox

Acne or unhealthy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Sensitivity to fragrances, exhaust, strong odors	0	1	2	3
History of environmental or chemical sensitivity	Yes		No	
Low tolerance to alcohol	0	1	2	3
Adverse reaction from sulfite-containing foods, such as wine, dried fruit, salad bar veggies, etc.	0	1	2	3
Use of Acetaminophen (Tylenol) -- Current☐ Past☐			years	
Use of SSRIs (Zoloft, Prozac) -- Current☐ Past☐			years	
Use BCP or estrogen -- Current☐ Past☐			years	
Use plastic bottles	0	1	2	3
Microwave plastic or hot liquids in styrofoam	0	1	2	3
Sensitivity of caffeine or coffee	0	1	2	3
History of exposure to chemicals: herbicides, pesticides, paint or cleaning products, etc.	Yes		No	

Panc/InsResist

Fatigue after meals	0	1	2	3
Crave sweets after meals	0	1	2	3
Lower back fat	0	1	2	3
Drink soda or juice	0	1	2	3
History of high triglycerides	Yes		No	

GB/FatAbsorp/Bile

Greasy or high-fat foods cause symptons	0	1	2	3
Clay colored or light colored stools	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Pain under right rib cage	0	1	2	3
Dry heels with cracked skin at the edges	0	1	2	3
History of gallstones	Yes		No	
Do you still have your gall bladder?	Yes		No	

↑Adrenals/SNS

Mid-section weight gain	0	1	2	3
Difficulty falling asleep	0	1	2	3
Feel restless, agitated, anxious, uneasy	0	1	2	3
Excessive perspiration with little or no activity	0	1	2	3
Rate your stress level 1 2 3 4 5 6 7 8 9 10				

AdrenalFatigue/Hypoglycem

I feel burned out or exhausted	0	1	2	3
Dizzy / light-headed when standing up quickly	0	1	2	3
Sensitivity to light	0	1	2	3
Slow starter in the morning	0	1	2	3
Irritable/light-headed after 3 hours without food	0	1	2	3
Crave salt	0	1	2	3
Do you eat breakfast?	Yes		No	
How many meals/snacks do you eat per day?			per day	

↑ Thyroid

Heart palpitations/flutters (not from heart condition)	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

↓ Thyroid

Tired or sluggish	0	1	2	3
Cold hands, feet, or all over	0	1	2	3
Require excessive sleep to function properly	0	1	2	3
Increased weight, even with restrictive diet	0	1	2	3
Difficult or infrequent bowel movements	0	1	2	3
Hair loss, hair falling out (any place on body)	0	1	2	3
Depression / lack of motivation	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness / brain fog	0	1	2	3
Outer 1/3 of eyebrows thin	0	1	2	3

Cardiovascular

Swollen ankles/feet	0	1	2	3
High blood pressure -- Current☐ Past☐	0	1	2	3
Heart arrythmia	0	1	2	3
High homocysteine (above 8)	0	1	2	3
High CRP (above 1.0)	0	1	2	3

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Brain/Cog/Memory

Inability to focus/concentrate	0	1	2	3
Brain fog	0	1	2	3
Declining memory -- short term or long term (circle one)	0	1	2	3
Headaches	0	1	2	3
Depression -- Current☐ Past☐ Years_____	0	1	2	3
Anxiety -- Current☐ Past☐ Years_____	0	1	2	3
Family history of diabetes/dementia	Yes		No	

Immune/Infections

Frequent colds/flu -- Frequency __________	0	1	2	3
History of Mono / Epstein-Bar / Herpes (circle which)	0	1	2	3
Food allergis	0	1	2	3
Airborne allergies	0	1	2	3
Excess mucus -- color of mucus	0	1	2	3
Enlarged lymph nodes	0	1	2	3
Diagnosed (or think you have) auto-immune issues	0	1	2	3

MENSTRUATING FEMALES ONLY

Are you pregnant ? If yes, how many weeks _____	Yes		No	
Perimenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle (greater than 32 days)	Yes		No	
Shortened menstrual cycle (less than 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
Pelvin pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hormonal birth control -- Current☐ Past☐ Years_____				
Infertility	0	1	2	3
Endometriosis	0	1	2	3
Ovarian cysts	0	1	2	3
Uterine fibroids	0	1	2	3
Vaginal infections	0	1	2	3

MALES ONLY

Decreased drive/motivation with life	0	1	2	3
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of 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
Decreasd physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
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
Urination difficulty or dribbling	0	1	2	3
Frequent urination at night	0	1	2	3

LIFESTYLE

How many caffeinated beverages do you consume per day? ______

How many alcoholic beverages do you consume per week? ______

How many times do you eat out per week? ______

List the three worst foods you eat during the average week.

1) 2) 3)

List the three healthiest foods you eat during the average week.

1) 2) 3)

What type of exercise do you do?	Times/week
1.	
2.	
3.	
4.	

MENOPAUSAL FEMALES ONLY

How many years have you been menopausal?			years	
Was menopause natural or surgical? (circle one)				
Since menopause, do you ever have uterine 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
Hormonal replacement therapy -- Current☐ Past☐ Years_____				

List any medications you currently take, and for what condition(s). ____________________

List any suupplements you currently take, and for what condition(s). ____________________