

Alder Brooke Healing Arts

Metabolic Screening Questionnaire

Client Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile.

INITIAL TEST RETEST- Initial Test Date _____

- 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

HEAD ___ Headaches ___ Faintness ___ Dizziness ___ Insomnia <div style="text-align: right;">Total _____</div>	MOUTH/THROAT ___ Chronic coughing ___ Gagging, frequent need to clear throat ___ Sore throat, hoarseness, loss of voice ___ Swollen or discolored tongue, gums or lips <div style="text-align: right;">Total _____</div>
EYES ___ Watery or itchy eyes ___ Swollen, reddened or sticky eyelids ___ Bags or dark circles under eyes ___ Blurred or tunnel vision <div style="text-align: right;">Total _____</div>	SKIN ___ Acne ___ Hives, rashes, dry skin ___ Hair loss ___ Flushing, hot flashes ___ Excessive sweating <div style="text-align: right;">Total _____</div>
EARS ___ Itchy Ears ___ Earaches, ear infections ___ Drainage from ear ___ Ringing in ears, hearing loss <div style="text-align: right;">Total _____</div>	HEART ___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat ___ Chest pain <div style="text-align: right;">Total _____</div>
NOSE ___ Stuffy nose ___ Sinus problems ___ Hay fever ___ Sneezing attacks ___ Excessive mucus formation <div style="text-align: right;">Total _____</div>	LUNGS ___ Chest congestion ___ Asthma, bronchitis ___ Shortness of breath ___ Difficulty breathing <div style="text-align: right;">Total _____</div>

- 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

<p>DIGESTIVE TRACT</p> <p><input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating feeling <input type="checkbox"/> Belching, passing gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal/stomach pain</p> <p style="text-align: right;">Total _____</p>	<p>ENERGY/ACTIVITY</p> <p><input type="checkbox"/> Fatigue, sluggishness <input type="checkbox"/> Apathy, lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness</p> <p style="text-align: right;">Total _____</p>
<p>JOINTS/MUSCLES</p> <p><input type="checkbox"/> Pain or aches in joint <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or limitation of movement <input type="checkbox"/> Pain or aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness</p> <p style="text-align: right;">Total _____</p>	<p>MINDS</p> <p><input type="checkbox"/> Poor memory <input type="checkbox"/> Confusion, poor comprehension <input type="checkbox"/> Poor concentration <input type="checkbox"/> Difficulty in making decisions <input type="checkbox"/> Stuttering or stammering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Learning disabilities</p> <p style="text-align: right;">Total _____</p>
<p>WEIGHT</p> <p><input type="checkbox"/> Binge eating/drinking <input type="checkbox"/> Craving certain foods <input type="checkbox"/> Excessive weight <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Water retention <input type="checkbox"/> Underweight</p> <p style="text-align: right;">Total _____</p>	<p>EMOTIONS</p> <p><input type="checkbox"/> Mood swings <input type="checkbox"/> Anxiety, fear, nervousness <input type="checkbox"/> Anger, irritability, aggressiveness <input type="checkbox"/> Depression</p> <p style="text-align: right;">Total _____</p>
<p>OTHER</p> <p><input type="checkbox"/> Frequent illness <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> General itch or discharge</p> <p style="text-align: right;">Total _____</p>	<p style="text-align: right;">GRAND TOTAL _____</p>

Notes: _____
