Metabolic Fitness Symptom Assessment

Answer the following questions on a scale of "0" (least/never/zero symptoms), "1" (minor, mild, rarely, monthly), "2" (moderate, occasionally, weekly), to "3" (most, severe, frequently, daily). Take your time and be honest with the answers; the more accurate you the better your will understand which systems are a priority for you.

Score 1

Crave sweets and/or carbohydrates	0 1 2 3
Crave sweets after meals	0 1 2 3
Frequent thirst	0 1 2 3
Feel tired after meals	0 1 2 3
Blurred vision	0 1 2 3

Total _____

Score 2

Shaky and irritable between meals	0 1 2 3
Eating energizes me and/or relieves fatigue	0 1 2 3
Often wake up during the night	0 1 2 3
Fatigue, fuzzy thinking, headaches between meals	0 1 2 3
Anxiety and palpitations	0 1 2 3

Total _____

Score 3

Difficult time getting going in the morning	0 1 2 3
Difficulty falling asleep, a "night person"	0 1 2 3
Feel "tired and wired"	0 1 2 3
Perspire easily, even with minimal activity	0 1 2 3
Elevated blood pressure	0 1 2 3

Total _____

Score 4

Crave salt or liberally salt food	0 1 2 3
Lightheaded when standing up quickly	0 1 2 3
Difficulty staying asleep	0 1 2 3
Low blood pressure	0 1 2 3
Fatigue and/or depression	0 1 2 3

Total _____

Score 5

Bloating shortly after a meal	0 1 2 3
Experience heartburn, or use antacids	0 1 2 3
Excessive belching or burping	0 1 2 3
Sensitive to a number of foods	0 1 2 3
Indigestion or nausea after eating	0 1 2 3

Total _____

Score 6

Excessive and/or foul-smelling gas	0 1 2 3
Lower abdominal bloating relieved by gas	0 1 2 3
Constipation, diarrhea, both (circle which apply)	0 1 2 3
History of antibiotic use	0 1 2 3
History of laxative use	0 1 2 3

Total _____

Score 7

Nausea or diarrhea from high-fat foods	0 1 2 3
"Greasy" stool that tends to float	0 1 2 3
Sensitive to caffeine, alcohol, and/or other synthetic Chemicals	0 1 2 3
General itchiness, or itchy palms	0 1 2 3
Gall bladder removed: Yes (3) No (1)	

Total _____

Score 8

Tendency to be cold, especially hands and feet	0 1 2 3
Difficulty losing weight	0 1 2 3
Low energy, or tired all the time	0 1 2 3
Brain fog, mental sluggishness	0 1 2 3
Dry skin, brittle nails, hair loss	0 1 2 3

Total _____

Score 9 (Males)

Decreased libido	0 1 2 3
Decrease in morning erections or strength in Erections	0 1 2 3
Decreased enjoyment in life	0 1 2 3
Decreased strength and/or endurance	0 1 2 3
Difficulty building or maintain muscle	0 1 2 3

Total _____

Score 10 (Females - Menstruating)

Acne and/or unwanted facial hair growth	0 1 2 3
Abnormal menstruation (heavy, extended, shortened, scanty)	0 1 2 3
Pain, cramping, and/or breast tenderness during menses	0 1 2 3
Significant mood changes during menses	0 1 2 3
Currently taking, or history of taking, birth control	0 1 2 3

Total _____

Score 11 (Females – Menopausal)

Experience hot flashes	0 1 2 3
Acne and/or unwanted facial hair growth	0 1 2 3
Mood swings, depression, night sweats	0 1 2 3
Vaginal thinning, dryness, or itchiness	0 1 2 3
Low libido	0 1 2 3

Total _____

Score 12

Bleeding gums or nosebleeds, or easily bruised	0 1 2 3
Muscle fatigue or excessive soreness after exercise	0 1 2 3
Tingling in hands or feet, and/or cracks in the corners of the mouth	0 1 2 3
Restless legs and/or muscle cramping/twitching	0 1 2 3
Dry/scaly skin and/or bumps on the back of the arms	0 1 2 3

Total _____

Score 13

Feel tired, fatigued, or weak	0 1 2 3
Experience shortness of breath	0 1 2 3
Coldness in hands and feet, or "poor circulation"	0 1 2 3
Experience a rapid, or irregular, heart beat	0 1 2 3
Dizziness or lightheadedness	0 1 2 3

Total _____

Score 14

Lack of motivation	0 1 2 3
Feelings of worthlessness, or self-destructive thoughts	0 1 2 3
Quick to anger or frustration	0 1 2 3
Inattentive, poor circulation, disorganized thinking	0 1 2 3
Decreased pleasure in life	0 1 2 3

Total _____

Score 15

Loss of enjoyment in favorite activities, or relationships	0 1 2 3
Feelings of depression and sadness	0 1 2 3
Gut distress and/or decreased pain tolerance	0 1 2 3
Feelings of overwhelm, or obsessive thoughts	0 1 2 3
Lack of deep, restful sleep	0 1 2 3

Total _____

Score 16

Feelings of anxiety, panic or inner tension	0 1 2 3
Experience restlessness, mentally or physically	0 1 2 3
Easily worried	0 1 2 3
Feel easily overwhelmed and overworked	0 1 2 3
Insomnia or difficulty	0 1 2 3

Total _____

Score 17

Sensitive to the smell of gasoline, paint, cleaning products, perfumes, or other fragrances	0 1 2 3
I live, or work near, heavy traffic, industrial plants, farms, or electricity, or cell phone, towers	0 1 2 3
Chronic airways issues including nasal congestion, mucous production, or throat or nasal irritation	0 1 2 3
Chronic headaches, muscle or joint stiffness or pain, or skin issues (circle which apply)	0 1 2 3
Exposure to chemicals, i.e. synthetic fabrics, tap water, cosmetics, cleaning products, and processed foods	0 1 2 3

Total _____

Score 18

I feel as if nobody understands me	0 1 2 3
It is difficult for me to make friends	0 1 2 3
People are around me, but not with me	0 1 2 3
My social relationships are superficial	0 1 2 3
No one really knows me well	0 1 2 3

Total _____

Score 19

I feel in control of my life	0 1 2 3
Life is rewarding, I am optimistic about the future	0 1 2 3
I am satisfied with my life	0 1 2 3
I feel healthy, attractive, and am pleased with who I am	0 1 2 3
I find beauty and joy in things, and laugh often	0 1 2 3

Total _____

Score 20

I can easily, succinctly articulate my purpose in life	0 1 2 3
I have discovered who I really am	0 1 2 3
I get intensely involved in, and feel greatly fulfilled By, many of the things I do each day	0 1 2 3
My life is centered around a set of core beliefs that give meaning to my life	0 1 2 3
It is more important that I enjoy what I do, rather than if people are impressed by it	0 1 2 3

Total _____

Page 1 Total _____

Page 2 Total _____

Grand Total _____