

Metabolic Assessment Form Key

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

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

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please circle the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

Category I: Colon				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	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 of "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
Do you use laxatives frequently	0	1	2	3
Category II: Hypochloridia				
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 and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
Category III: Hyperacidity (Ulcer)				
Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3
Category IV: Small Intestine (Pancreas)				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Excessive passage of gas	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 and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category V: Biliary Insufficiency/Stasis				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes	No		
Category VI: Hypoglycemia				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or 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	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII: Insulin Resistance				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	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: Adrenal Hypofunction				
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 with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX: Adrenal Hyperfunction

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 even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X: Hypothyroid

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with 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
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI: Thyroid Hyperfunction

Heart palpitations	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: Pituitary Hypofunction

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII: Pituitary Hyperfunction

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Male Only): Prostate

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): Andropause

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 maintain 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 and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional then 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?				
Do you ever have uterine bleeding since menopause?	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

PART III: Foods

How many alcohol beverages they consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

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

How many times a week do you eat fish? _____

How many times a week do you workout? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Do you smoke? _____ If yes, how many times a day _____, a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

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

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Patient Name: _____ Date: _____

CANDIDA QUESTIONNAIRE

Candida Albicans is a yeast infection, both digestive and systemic. Literally millions of men and women have a potential yeast infection that is causing a significant number of health problems or conditions.

This questionnaire lists factors in your medical history that promote the growth of the common yeast, Candida Albicans and symptoms commonly found in individuals with yeast-connected illnesses.

If you think your health is being affected by Candida and would like help in eliminating it from your body, schedule a session with Dr. Jennifer Amundson to find out what you can do to live a better and healthier life!

SECTION A: HISTORY

INSTRUCTIONS: For each YES question in section A, circle the point score in that section. Total your score and record it in the box at the end of the section. Then move on to Section B and Section C scoring as directed.

1	Have you taken Tetracycline (Sumycin, Pamyacin, Vibramycin, Minocin, etc.) or any other antibiotic for acne for 1 month or longer?	50
2	Have you ever taken other broad spectrum antibiotic therapy for urinary, respiratory, or other infections for 2 months or longer or in shorter courses 4 or more times in a 1 year period?	50
3	Have you ever taken a broad spectrum antibiotic –even for one period?	6
4	Have you ever been bothered by persistent prostatitis, vaginitis, or other problems that affect your reproductive organs?	25
5	Have you ever been pregnant- 2 or more times	5
6	Have you taken birth control pills for more than 2 years?	15
7	Have you taken Prednisone, Decadron, or other Cortisone type drugs for more than 2 weeks?	8
8	Does exposure to perfumes, insecticides, fabric shop odors, or other chemicals provoke Moderate or Severe Symptoms?	15
9	Mild symptoms	6
9	Are symptoms worse on damp, muggy days or in moldy places?	20

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10	Have you had athlete's foot, ring worm, jock itch, or other chronic fungous infections of the skin or nails?	20
	Moderate to severe symptoms	
	Mild to moderate	10
11	Do you crave sugar?	10
12	Do you crave breads or other foods high in carbohydrates?	10
13	Do you crave alcoholic beverages?	10
14	Does tobacco smoke really bother you?	10
TOTAL SCORE:		

SECTION B: MAJOR SYMPTOMS

INSTRUCTIONS: For each symptom that is present, enter the appropriate number in the Point Score Column

If a symptom is occasional or mild.....3 points
 If a symptom is frequent and/or moderately severe.....6 points
 If a symptom is severe and/or disabling.....9 points

Total the score for this section and record it in the box at the end of the section.

1	Fatigue or Lethargy	3	6	9
2	Feeling of being drained	3	6	9
3	Poor memory	3	6	9
4	Feeling spacey or unreal	3	6	9
5	Depression	3	6	9
6	Numbness, burning, or tingling	3	6	9
7	Insomnia	3	6	9
8	Muscle aches	3	6	9
9	Muscle weakness, or paralysis	3	6	9
10	Joint pain or swelling	3	6	9
11	Abdominal pain	3	6	9
12	Constipation	3	6	9
13	Diarrhea	3	6	9
14	Bloating, belching, or intestinal gas	3	6	9
15	Troublesome vaginal burning, itching or discharge	3	6	9
16	Prostatitis	3	6	9

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17	Impotence	3	6	9
18	Loss of sexual desire or feeling	3	6	9
19	Endometriosis or infertility	3	6	9
20	Cramps and or other menstrual irregularities	3	6	9
21	Pre-menstrual tension	3	6	9
22	Attacks of anxiety or crying	3	6	9
23	Cold hands or feet, and or chilliness	3	6	9
24	Shaking or irritable when hungry	3	6	9
TOTAL SCORE:				

SECTION C: OTHER SYMPTOMS

INSTRUCTIONS: For each symptom that is present, enter the appropriate number in the Point Score Column

If a symptom is occasional or mild.....3 points
 If a symptom is frequent and/or moderately severe.....6 points
 If a symptom is severe and/or disabling.....9 points

Total the score for this section and record it in the box at the end of the section.

1	Drowsiness	3	6	9
2	Irritability or jitteriness	3	6	9
3	In-coordination	3	6	9
4	Inability to concentrate	3	6	9
5	Frequent mood swings	3	6	9
6	Headache	3	6	9
7	Dizziness or loss of balance	3	6	9
8	Pressure above ears, feeling of head swelling/tingling	3	6	9
9	Tendency to bruise easily	3	6	9
10	Chronic rashes or itching	3	6	9
11	Psoriasis or recurrent hives	3	6	9
12	Indigestion or heartburn	3	6	9
13	Food sensitivity or intolerance	3	6	9
14	Mucus in stools	3	6	9

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15	Hemorrhoids or rectal itching	3	6	9
16	Dry mouth or throat	3	6	9
17	Rash or blisters in mouth	3	6	9
18	Bad breath	3	6	9
19	Foot, hair, or body odor not relieved by washing	3	6	9
20	Nasal congestion, discharge, or post nasal drip	3	6	9
21	Nasal itching	3	6	9
22	Sore or dry throat	3	6	9
23	Laryngitis, loss of voice	3	6	9
24	Cough or recurrent bronchitis	3	6	9
25	Wheezing or shortness of breath	3	6	9
26	Urgency frequency, urgency or incontinence	3	6	9
27	Burning on urination	3	6	9
28	Spots in front of eyes or erratic vision	3	6	9
29	Burning or tearing of eyes	3	6	9
30	Recurrent infections or fluid in ears	3	6	9
31	Ear pain or deafness	3	6	9
32	Pain or tightness in chest	3	6	9
TOTAL SCORE: C				
TOTAL SCORE: A				
TOTAL SCORE: B				
GRAND TOTAL SCORE:				

Yeast-connected health problems are almost certainly present in scores over

Women: 180points Men: 140 points

Yeast-connected health problems are probably present in scores over

Women: 120 points Men: 90 points

Yeast-connected health problems are possibly present in scores over

Women: 60 points Men: 40 points

With scores less than 60 women/ 40 men, yeast are less apt to cause health problems.

For more information, please check out the book: *The Yeast Connection and Women's Health* by William Crook, MD