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 your answer 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 (0)
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 _________
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