Name:____ Date_________________

Metabolic - Part 1a

Primary Complaint: Weight Loss - Obesity - Weight Gain - Thyroid or Pituitary Disorder - Diabetes Type II - Insulin Resist

Instructions: There are six (6) pages of 'Fill-In' pdf forms. Please provide as much information as possible - this is your opportunity to tell me what has been occurring in the past, your current condition as well as concerns you have for your future should this condition continue.

Name your Primary Complaint: ☐ Desire Weight Loss ☐ Treat Obesity ☐ Desire Weight Gain ☐ Support Thyoid Disorder ☐ Support Diabetes ☐ Treat Insulin Resistance ☐ Other ____________

Indicate all abnormalities or exacerbated conditions that occur simultaneously with your Primary Complaint:

☐ Balance	☐ Appetite	☐ Blood pressure	☐ Energy	☐ Addiction	☐ Fertility
☐ Hearing	☐ Defecation	☐ Arrythmias	☐ Libido	☐ Attitude change	☐ Pain (physical)
☐ Smell	☐ Digestion	☐ Angina	☐ Menses	☐ Behavior change	☐ Twitching-Tics
☐ Speech	☐ Thirst	☐ Breathing	☐ Vaginal fluids	☐ Cravings	☐ Hiccups
☐ Swallowing	☐ Urination	☐ Skin	☐ Semen flow	☐ Emotions	☐ Self Esteem
☐ Taste	☐ Bleeding	☐ Hair	☐ Sleep	☐ Mental function	☐ Self Image
☐ Touch	☐ Mucus flow	☐ Nails	☐ Excess naps	☐ Memory	☐ Motivation
☐ Vision	☐ Swelling			☐ Pain (from emotions)	

Is this your first time seeking treatment for the primary complaint? ☐ Yes ☐ No, I have sought ______ prior.
No. of times

When did the primary complaint become disruptive to your ADL, caused significant impairment or prompted treatment?

____
How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

____
Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

____
Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? ____________________________

____

What provides relief to the primary complaint? _________

____

____

____

Please answer the following:

Are you willing to have blood tests?	☐ No	☐ Yes	☐ Unknown
Does excess weight caused pain?	☐ No	☐ Yes	☐ Unknown
Has excess weight damaged joints?	☐ No	☐ Yes	☐ Unknown
Does a sibling have this weight issue?	☐ No	☐ Yes	☐ Unknown
Does a parent have this weight issue?	☐ No	☐ Yes	☐ Unknown
Are you lactose intolerant?	☐ No	☐ Yes	☐ Unknown
Are you gluteomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Are you caseomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Do you have a food allergy?	☐ No	☐ Yes	☐ Unknown
Are you on prescription medication?	☐ No	☐ Yes	
Are you taking OTC medicines?	☐ No	☐ Yes	
Are you taking illicit drugs?	☐ No	☐ Yes	
Are you taking herbs?	☐ No	☐ Yes	
Do you smoke tobacco?	☐ No	☐ Yse	

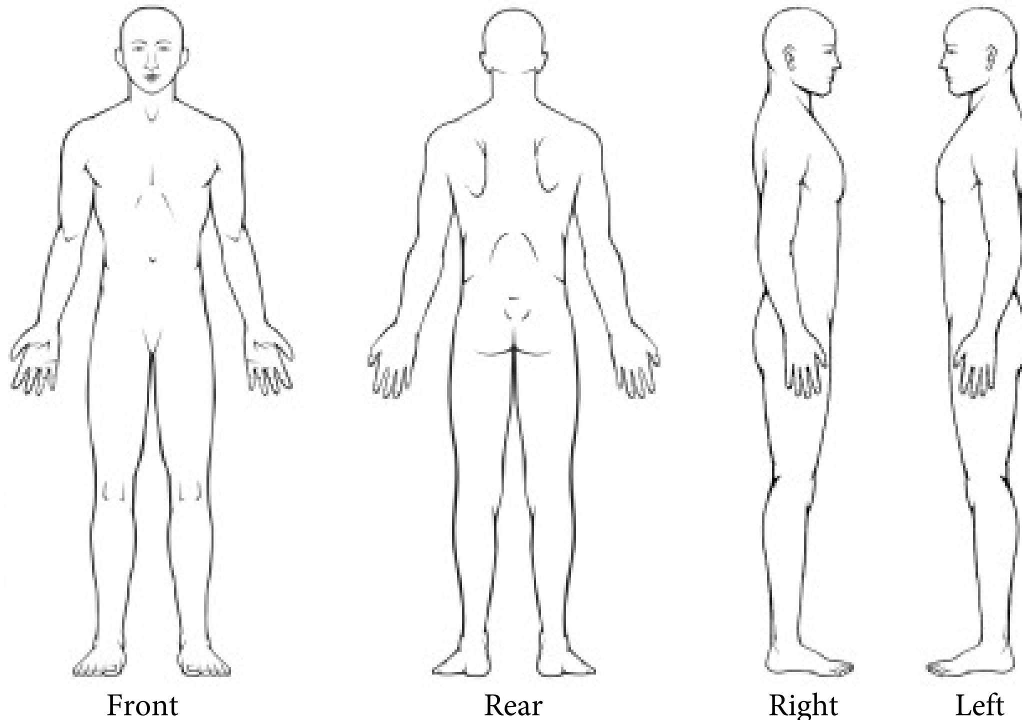
If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint. Example: John_Doe_Metabolic Part 1a

Name:______________________________________ Date_________________

Metabolic - Part 1b

Primary Complaint: Weight Loss - Obesity - Weight Gain - Thyroid or Pituitary Disorder - Diabetes Type II - Insulin Resist

Instructions: Please place a "X" on the area of Pain or Sensation.



Type of Pain or Sensation:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Cramping
- ☐ Tightening
- ☐ Stiffness
- ☐ Swelling
- ☐ Heat
- ☐ Cold
- ☐ Crawling
- ☐ Itching

Quality.of Primary Complaint:

- ☐ Constant
- ☐ Fixed
- ☐ Intermittent
- ☐ Moving

Trigger or Aggrivated by:

- ☐ Cold
- ☐ Heat
- ☐ Physical activity
- ☐ Emotional upset
- ☐ Stress
- ☐ Weather

Rate your pain at it's most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere's significantly with ADLs
- ☐ 5 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 6 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 7 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 8 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 9 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 10 Severe - Disabling, unable to perform ADLs & Need hospital

What provides relief of Pain or sensation?

____

____

Other comments:

____

____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Metabolic Part 1b

Metabolic Assessment Form - Part 1c™

Name: ____________________ **Age:** ______ **Sex:** _____ **Date:** ______________

PART I

Please list your 5 major health concerns in order of importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

PART II

Please check the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved 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 or "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
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

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 food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or 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 VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*

Nausea and/or vomiting	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

Category VII

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
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	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 VIII

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have 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 X

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 and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

© 2013 Datis Kharrazian. All Rights Reserved.

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Symptom				
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 XII

Symptom				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount 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 XIII

Symptom				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Symptom				
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 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 hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Symptom				
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

Category XV *(Cont.)*

Symptom				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*

Symptom				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Symptom				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining 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
Decreased 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

Category XVIII *(Menstruating Females Only)*

Symptom				
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
Pelvic 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
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

Symptom				
How many years have you been menopausal?	_______ years			
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

PART III

How many alcoholic beverages do you consume per week? _________

How many caffeinated beverages do you consume per day? _________

How many times do you eat out per week? _________

How many times do you eat raw nuts or seeds per week? _________

Rate your stress level on a scale of 1-10 during the average week: _________

How many times do you eat fish per week? _________

How many times do you work out per week? _________

List the three worst foods you eat during the average week: ____________________ ____________________ ____________________

List the three healthiest foods you eat during the average week: ____________________ ____________________ ____________________

© 2013 Datis Kharrazian. All Rights Reserved.

Name:____ Date_________________

Use the next four (4) pages to embellish upon the details of your Primary Complaint and Life Experiences.

Metabolic - Part 2

Primary Complaint: Weight Loss - Obesity - Weight Gain - Diabetes Type II, Insulin Resistance -Thyroid Disorder

Instructions: The Day Your Primary Complaint became disruptive to your ADL or caused significant impairment

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order starting with the morning of and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012. Then describe the following:

- where you were located when you noticed the problem (or a medical diagnosis that was given),
- how you felt and any pain and/or emotional responses
- what ADL you could not do or what bodily functions were significantly impaired
- the duration of the symptom(s) and characteristics (qualities)
- anything that seemed to make it worsen or improve it
- any observations by other people of your behavior, emotions or physical condition

Date your Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Metabolic Part 2

Name:____ Date_________________

Metabolic - Part 3

Primary Complaint: Weight Loss - Obesity - Weight Gain - Diabetes Type II, Insulin Resistance - Thyroid Disorder

Instructions: Your Life Prior to the Day the Primary Complaint became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back to the earliest date when you noticed the Chief Complaint and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be ‘mid-November 2011’, or sometime in the summer of 2009, or it might be as specific as the morning of New Year’s Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Primary Complaint became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moving your home changing jobs marriage divorce separation
  pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters
  child rearing problems children leaving home for college child custody illness accidents incarceration
  institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date of earliest recall of Primary Complaint or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Metabolic Part 3

Name:____ Date_________________

Metabolic - Part 4

Primary Complaint: Weight Loss - Obesity - Weight Gain - Diabetes Type II, Insulin Resistance - Thyroid Disorder

Instructions: Your Life 1 year Prior to the Earliest Date you noticed the Primary Complaint or associated symptoms cited in Part 3.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back 1 year prior to the earliest date when you noticed the Chief Complaint and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Primary Complaint became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date 1 year prior to the earliest recall of the Primary Complaint or associated symptoms:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint. Example: John_Doe_Metabolic Part 4

Name:____ Date_________________

Metabolic - Part 5

Primary Complaint: Weight Loss - Obesity - Weight Gain - Diabetes Type II, Insulin Resistance - Thyroid Disorder

Instructions: **Your Symptoms and Actions since the day your Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment cited in Part 2.**

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Describe to best of you abilities the chronological sequences of the following starting from the Day the Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment through to today. Include the following:
  - changes of the symptoms over time (duration, intensity, improvements, worsening, etc)
  - the actions you have employed to treat the problem via MD, ND, DO, DC, LAc, PT and other therapists as well as home remedies. Include the diagnosis, therapies, medications and natural remedies (herbs, homeopathy, nutritional) that have been used. Include any and all improvements or worsening of the problem/condition due to any of the actions you employed.
- Include the events of your life that occurred during this tme period. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Symptoms and Actions since the Primary Complaint or associated symptoms became disruptive to ADL or causative to significant impairment:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Metabolic Part 5

PATIENT NAME: ____ Date____________________

Metabolic - Part 6

Primary Complaint: Desired Weight Loss Or Treat Obesity

PROGRESSION OF WEIGHT GAIN PATTERN (AGE 18 TO CURRENT):

No pattern

Steady, gradual increase of weight over the years

Sudden increases of weight with pregnancies

Variable weight gain/loss due to intermittent diet and exercise (regained weight when stopped program)

EXERCISE HISTORY: What is your exercise program?

☐ I am unable to exercise due to - severe joint pain shortness of breath wheelchair/bed

☐ I am able to exercise but I do not have a regular routine

☐ I walk / run ___ times per week for ____ minutes

☐ I swim ____ times per week for ______ minutes

☐ I lift weights ____ times per week for ____ minutes

Other – (please explain) ____

DIETARY HISTORY: What do you consider to be your daily eating pattern? **(√ all that apply)**

☐ Less than normal ☐ Normal ☐ Overeat ☐ Binge ☐ Serious eating disorder ☐ Excessive snacking

Do you eat/snack just before bedtime? ☐ No ☐ Yes

Which meals do you eat each day? ☐ Breakfast ☐ Lunch ☐ Supper ☐ Snacks

What and how much do you usually eat for breakfast? ____

What and how much do you usually eat for lunch? ____

What and how much do you usually eat for supper? ____

What are your favorite snacks? ____

How much of them do you eat per sitting? ____

Do you drink pop? ☐ No ☐ Yes – How many 12oz servings per day? DIET ____ REGULAR ____

Do you drink Juice? ☐ No ☐ Yes - What kind? ______________________ How much per day? _________

PATIENT NAME: ____ Date____________________

Metabolic - Part 6

Primary Complaint: Desired Weight Loss Or Treat Obesity

List supervised diet attempts over the past 5 years (most recent first)

Please use the following acronyms for the following:
WW - Weight Watchers JC - Jenny Craig NS - Nutri-System Oth - Other

Name/type of diet attempt____

Dates on diet (**month/year**) _____/______ to _____/______ (# of months_________)

Beginning weight___________ pounds lost ___________ pounds gained___________

Supervised: Medically____, Licensed/Registered Dietitian____, Commercial program____, Self ____

Name/type of diet attempt____

Dates on diet (**month/year**) _____/______ to _____/______ (# of months_________)

Beginning weight___________ pounds lost ___________ pounds gained___________

Supervised: Medically____, Licensed/Registered Dietitian____, Commercial program____, Self ____

Name/type of diet attempt____

Dates on diet (**month/year**) _____/______ to _____/______ (# of months_________)

Beginning weight___________ pounds lost ___________ pounds gained___________

Supervised: Medically____, Licensed/Registered Dietitian____, Commercial program____, Self ____

Name/type of diet attempt____

Dates on diet (**month/year**) _____/______ to _____/______ (# of months_________)

Beginning weight___________ pounds lost ___________ pounds gained___________

Supervised: Medically____, Licensed/Registered Dietitian____, Commercial program____, Self ____