CLIENT METABOLIC SCREENING QUESTIONNAIRE

Date: ……General Practitioner…….. .

Name: ……...…….. .

DOB …. /…../….. Current medications:……..

…….

…….

Allergies to Medication…… Food allergies……
……..

Past Medical/Surgical History:……

Date:……
Date:……
Date:……
Date:…….....

Social History: single/married/defacto……

…….....

Obstetric History……P……G……

Smoking History:……Y/N……Per Day……start date……Quit date…….....

Alcohol History……Y/N……Per Day……..

Family Medical History……...

Maternal:……Paternal……

Reason/s for consultation……

……
……

METABOLIC SCREENING QUESTIONNAIRE

Rate each of the following symptoms based upon your health profile for the past 30 days

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

DIGESTIVE TRACT	_____	Nausea or Vomiting	TOTAL
	_____	Diarrhoea	
	_____	Constipation	
	_____	Belching, or passing gas	
	_____	Heartburn	
	_____	Intestinal/Stomach Pain	_____
EARS	_____	Itchy Ears	TOTAL
	_____	Ear Aches, Ear infections	
	_____	Drainage from Ear	
	_____	Ringing in Ears, hearing loss	_____
EMOTIONS	_____	Mood swings	TOTAL
	_____	Anxiety, fear or nervousness	
	_____	Anger, irritability, or aggressiveness	
	_____	Depression	_____
ENERGY / ACTIVITY	_____	Fatigue, sluggishness	TOTAL
	_____	Apathy ,lethargy	
	_____	Hyperactivity	
	_____	Restlessness	_____
EYES	_____	Watery or itchy eyes	TOTAL
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	
		(does not include near or far sightedness)	_____
HEAD	_____	Headaches	TOTAL
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	_____
HEART	_____	Irregular or skipped heartbeat	TOTAL
	_____	Rapid or pounding heartbeat	
	_____	Chest Pain	_____

JOINTS/ MUSCLES	_____ Pain or aches in Joints/ Muscles	TOTAL
	_____ Arthritis	
	_____ Stiffness or limitation of movement	
	_____ Feeling of weakness or tiredness	_____
LUNGS	_____ Chest congestion	TOTAL
	_____ Asthma, bronchitis	
	_____ Difficulty breathing	_____
MIND	_____ Poor Memory	TOTAL
	_____ Confusion, poor comprehension	
	_____ Poor concentration	
	_____ Poor physical coordination	
	_____ Difficulty in making decisions	
	_____ Stuttering or stammering	
	_____ Slurred speech	
	_____ Learning disabilities	_____
MOUTH/THROAT	_____ Chronic coughing	TOTAL
	_____ Gagging, frequent need to clear throat	
	_____ Sore throat, hoarseness ,loss of voice	
	_____ Swollen or discoloured tongue, gums, lips	
	_____ Mouth Ulcers	_____
NOSE	_____ Stuffy nose	TOTAL
	_____Sinus problems	
	_____ Hay fever	
	_____ Sneezing attacks	
	_____ Excessive mucous formation	_____
SKIN	_____ Acne	TOTAL
	_____ Hives ,rashes ,or dry skin	
	_____ Hair Loss	
	_____ Flushing or hot flushes	
	_____ Excessive sweating	_____
WEIGHT	_____ Binge eating/drinking	TOTAL
	____ Craving certain foods	
	____ Excessive weight	
	____ Compulsive eating	
	____ Water retention	
	____ Underweight	_____

OTHER	____ Frequent illness	TOTAL
	____ Frequent or urgent urination	
	____ Genital itch or discharge	_____

GRAND TOTAL _____

COMMENTS

PLEASE ANSWER THE FOLLOWING QUESTIONS BY (TICKING BOX) MOST APPROPRIATE ANSWER

	Yes	No
1. Have you been treated with antibiotics?	☐	☐
2. Have you ever had problems with yeast infections?	☐	☐
3. Do you eat or crave a lot of sweet foods?	☐	☐
4. Do you have a problem with food allergies?	☐	☐
5. Have you suffered from food poisoning?	☐	☐
6. Do you or have you consumed alcohol on a regular basis?	☐	☐
7. Have you ever taken the drugs Tagamet or Zantac?	☐	☐
8. Do you take aspirin, panadeine or other pain killers?	☐	☐
9. Do you take any other types of drugs regularly?	☐	☐
10. Are you often in contact with organic chemicals?	☐	☐
(i.e.insecticides, herbicides, petro chemicals etc?)	☐	☐
11. Do you react to strong perfumes, car exhaust, etc?	☐	☐
12. Do you or have you ever smoked or used tobacco products?	☐	☐
13. Are you exposed to passive cigarette smoke?	☐	☐
14. Do you consume beverages/food containing caffeine?	☐	☐

LIVER DETOXIFICATION TEST (LDT) SCREENING QUESTIONS

A certain percentage of patients will experience adverse reactions during the LDT.

These reactions include, but are not limited to; shakiness, headaches, nausea, palpitations, light-headedness and sweating. The following questions will help isolate those patients who may experience these types of reactions.

A. Do you react when you consume caffeine-containing beverages or food?

_____

B. Are you sensitive to food additives such as MSG? _____

C. Do you have a history of liver problems? If YES please describe

_____

D. Are you currently taking any drugs? If YES, please list below