



PATIENT EVALUATION FORM

Full Name *

First Name Last Name

Address *

Street Address

City State / Province

Postal / Zip Code

Date of Birth *

Month Day Year

Mobile Phone *

Area Code Phone Number

Home Phone

Area Code Phone Number

Work Phone

Area Code Phone Number

Email Address *

Employer

of hours worked per week:

Gender *
 Male Female

of Children:

Marital Status *

Spouse's Name:

First Name Last Name

Emergency Contact: *

textbox_sample21 textbox_sample22

First Name

Last Name

Emergency Contact Number *

312 312

Area Code

Phone Number

Reason for your visit *

textbox_sample26

How did you hear about us?

textbox_sample27

DIAGNOSTIC EVALUATION

Have you been diagnosed with Diabetes? *

Yes

No

If yes, are you on medication? List here:

textbox_sample28

Have you been diagnosed with Thyroid Disease/Disorder? *

Yes

No

If yes, are you on medication? List here:

textbox_sample29

Have you been diagnosed with Autoimmune Disease? *

Yes

No

If yes, please explain:

textbox_sample30

Do you currently have or ever had any issues with your digestion or bowel elimination? *

Yes

No

If yes, please explain:

textbox_sample31

ADDITIONAL INFORMATION

Any additional medication(s):

Any additional medication(s):

textbox_sample32

Any additional supplement(s):

textbox_sample33

Number of Bowel Movements Daily: *

1

Hours of Sleep: *

1

METABOLIC ASSESSMENT FORM

NAME: *

John

First

Smith

Last

GENDER TYPE: *

Male

Female

AGE: *

1

PART I

Please list up to (5) major health concerns, in order of importance:

1. *

textbox_sample39

2. *

textbox_sample40

3. *

textbox_sample41

4.

textbox_sample42

5.

textbox_sample43

PART II

Please use this scale to rate your answers: 0 = Never 1 = Sometimes 2 = Very often 3 = 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

Abdominal intolerance to sugars and starches

0 1 2 3

Frequent bloating and distention after eating *

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 movement *

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 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 using antacids, food, milk or carbonated beverages *

Temporary relief using antacids, food, milk or carbonated beverages

0 1 2 3

Digestive problems subside with rest & relaxation

0 1 2 3

Heartburn due to spicy food, 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

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

Difficulty losing weight

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

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?

0 1 2 3

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 or 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 meal *

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

CATEGORY XI

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

Cannot fall asleep *

0 1 2 3

Perspire easily *

0 1 2 3

Under 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

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

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

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 XVI

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 XVII

Increased sex drive *

0 1 2 3

Tolerance to sugars reduced *

0 1 2 3

"Splitting" type headaches *

0 1 2 3

CATEGORY XVIII - (Males only)

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 XIX - (Males only)

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 XX - (Menstruating Females Only)

Do you still have a menstrual cycle?

Yes No

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 XXI - (Menopausal Females Only)

How many years have you been menopausal?

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

Increase 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 daily? *

On a scale 1-10, rate your stress level for an average week: *

How many times do you eat fish per week? *

How many times do you eat out per week?

How many times do you exercise per week? *

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

List the (3) worst foods you eat during the average week:

List the (3) healthiest foods you eat during the average week:

If you have any other questions or concerns, please list here:

**Upon completion of your Patient Evaluation, please send the forms to our office.
Alternatively, you may also bring the forms on the day of your appointment.
Thank you and we look forward to seeing you!**

**Fax: 770.948.2525
Email: drgatcha2@gmail.com**

