Metametrix® Clinical Laboratory

Personal Health Assessment

NAME: ____________________

Rate each of the following symptoms based upon your typical health profile over the last year.

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

	ENERGY/ACTIVITY
	Fatigue, sluggishness
	Apathy, lethargy
	Hyperactivity
	Restlessness
	Easy fatiguability or lack of endurance
	Headaches
	Faintness
	Dizziness
	Insomnia
	Subtotal

	EMOTIONAL/MENTAL
	Mood swings
	Anxiety, fear or nervousness
	Anger or irritability
	Depression
	Poor memory
	Confusion, poor comprehension
	Poor concentration
	Difficulty in making decisions
	Stuttering or stammering
	Slurred speech
	Learning disabilities
	Subtotal

	JOINTS/MUSCLES/SKIN
	Pain or aches in joints
	Stiffness or limitation of movement
	Pain or aches in muscles
	Feeling of weakness or tiredness
	Cramps in legs
	Acne
	Hives, rashes, or dry skin
	Hair loss
	Flushing or hot flashes
	Fingernail abnormalities (spots, ridges)
	Decreased sweating
	Night sweats
	Subtotal

	EARS/MOUTH/THROAT/NOSE/EYES
	Itchy ears
	Earaches, ear infections
	Ringing in ears, hearing loss
	Drainage from ear
	Stuffy nose
	Sinus problems
	Hay fever
	Excessive mucus formation, post-nasal drip
	Sneezing attacks
	Poor night vision
	Watery or itchy eyes
	Swollen, tender or sticky eyelids
	Bags or dark circles under eyes
	Blurred or tunnel vision (does not include near- or far-sightedness)
	Chronic coughing
	Sore throat, hoarseness, loss of voice
	Swollen or discolored tongue, gums, lips
	Canker sores
	Subtotal

	DIGESTIVE TRACT
	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Belching, or passing gas
	Heartburn
	Subtotal

	HEART/LUNGS
	Irregular or skipped heartbeat
	Rapid or pounding heartbeat
	Chest pain
	Chest congestion
	Asthma, bronchitis
	Shortness of breath
	Subtotal

	WEIGHT/OTHER
	Binge eating/drinking
	Craving certain foods
	Excessive weight
	Compulsive eating
	Water retention
	Underweight
	Frequent illness
	Frequent or urgent urination
	Genital itch or discharge
	Injury
	Subtotal
	TOTAL POINTS

Personal Information

Date: ____________________

Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: ____________________

Phone#: ____________________ Fax#: ____________________

E-Mail: ____________________

Age: ________________ Sex: ________________ Weight: ________________ Height: ________________

Personal Health Concerns

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Personal Health Goals

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Please list any supplements and/or medications taken regularly and the amounts (if known):

	Name/Brand	Dosage	Comments
Medications:			
Supplements:			
Others: (Including Herbs)			

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