WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____

Metabolic Intake Form

PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____

Occupation: _____

Who may we thank for referring you to our office?

Friend/Family: _____ Health Care Provider: _____

Online Search: _____ Other: _____

MEDICAL HISTORY

01 Do you or any family member have/had any of the following? Please put an "**X**" for you, and "**F**" for family

- ☐ Depression
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Gallbladder Disease
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Fatigue
- ☐ Brain Fog
- ☐ Hypoglycemia
- ☐ Anemia
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Intestine Problems
- ☐ Shortness of Breath
- ☐ High Cholesterol
- ☐ Headache
- ☐ Poor Sleep
- ☐ Dizziness
- ☐ Arthritis
- ☐ Carpal Tunnel
- ☐ Neuropathy/Nerve Problems
- ☐ Weight Gain
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Knee Pain

☐ **Please check here if you are interested in the practitioner to present a solution for all checked alignments you are experiencing.**

02 Is there a certain time of day any of these problems are better or worse?

_____

_____

03 Are you taking any medications/supplements? If yes, please list.

_____

_____

04 Are you pregnant? _____ How many children? _____ How many Pregnancies? _____
Are you breast feeding? _____

05 Any known allergies? If yes, please list.

_____

_____

06 Main Concerns:

1. _____ 3. _____
2. _____ 4. _____

07 How long have you had this/these concerns?

_____

_____

08 What effect does this have on your body functions or quality of life?

_____

_____

09 What would be different or better without this/these concerns?

- ☐ Diminished Stress
- ☐ Work
- ☐ More Energy
- ☐ Family
- ☐ Improved Self-Esteem
- ☐ Outlook
- ☐ Confidence
- ☐ Sleep

10 How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other: _____

11 How did the previous methods work for you?

_____

_____

12 What potential barriers do you foresee that would prevent the change you are looking for?

_____

_____

13 Do you feel it possible to eliminate or prevent these potential barriers?

_____

14 What outcome would you like to see for this to be a success for you?

_____

_____

15 Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I AM INTERESTED IN:

☐ Weight Loss ☐ Anti-Aging ☐ Long-Term Results

☐ Inch Loss ☐ Metabolism Support