

Dr. Richard E. Picard
Advanced Nutrition and Holistic Services

Patient Name _____ Date _____

Metabolic Screening Questionnaire

Rate each of the following symptoms based on your typical health profile for the past 30 days.

_____ No Symptoms, 1= Occasional Not Severe, 2= Occasional Severe, 3= Frequent Not Severe, 4= Frequent Severe

Head _____ Headache
 _____ Faintness
 _____ Dizziness
 _____ Insomnia Total _____

Eyes _____ Watery/Itchy
 _____ Reddened or sticky eyelids
 _____ Bags or Dark circles
 _____ Blurred Vision Total _____

Ears _____ Itchy
 _____ Earache
 _____ Infection
 _____ Drainage
 _____ Ringing Total _____

Nose _____ Stuffy Nose
 _____ Sinus Problems
 _____ Hay Fever/Allergies
 _____ Mucous Formation Total _____

Throat _____ Chronic coughing
 _____ Frequent need to clear throat
 _____ Sore throat/hoarseness
 _____ Discolored tongue/gums
 _____ Canker soars Total _____

Energy _____ Fatigue
 _____ Apathy/lethargy
 _____ Hyperactivity
 _____ Restlessness Total _____

Skin _____ Acne
 _____ Hives/rashes/dry skin
 _____ Hair Loss
 _____ Flushing/hot flashes
 _____ Excessive Sweating Total _____

Other _____ Frequent Illness
 _____ Frequent Urination
 _____ Genital Itch/discharge Total _____

Lungs _____ Chest Congestion
 _____ Asthma/bronchitis
 _____ Shortness of breath
 _____ Difficulty breathing Total _____

Emotions _____ Mood swings
 _____ Anxiety/fear/nervousness
 _____ Anger/irritability/aggressiveness
 _____ Depression Total _____

Digestive _____ Nausea/vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating
 _____ Belching/passing gas
 _____ Heart burn
 _____ Intestinal/stomach pain Total _____

Mind _____ Poor memory
 _____ Poor comprehension
 _____ Poor concentration
 _____ Difficulty making decisions
 _____ Stuttering/speech dysfunction
 _____ Learning disabilities Total _____

Musculoskeletal
 _____ Pain or aches in joints
 _____ Stiffness or limitations of movement
 _____ Pain or aches in muscles
 _____ Weak muscles Total _____

Weight _____ Binge eating/drinking
 _____ Craving certain foods (salty/sweet)
 _____ Excessive weight/ weight gain
 _____ Compulsive eating
 _____ Water retention
 _____ Underweight Total _____

Heart _____ Irregular beat
 _____ Rapid beat
 _____ Chest pain Total _____

Grand Total _____

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