Patient Name: _____ Date: _____

METABOLIC CLEARING THERAPY INITIAL TESTING SCALE

Rate each of the following symptoms based upon your typical health profile for the last 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	
	____ Diarrhea	
	____ Constipation	
	____ Bloated Feeling	
	____ Belching, or passing gas	
	____ Heartburn	**Total ____**
EARS	____ Itchy ears	
	____ Ear aches, ear infections	
	____ Drainage from ear	
	____ Ringing in ears, hearing loss	**Total ____**
EMOTIONS	____ Mood swings	
	____ Anxiety, fear or nervousness	
	____ Anger, irritability, or aggressiveness	
	____ Depression	**Total ____**
ENERGY/ACTIVITY	____ Fatigue, sluggishness	
	____ Apathy, lethargy	
	____ Hyperactivity	
	____ Restlessness	**Total ____**
EYES	____ Watery or itchy eyes	
	____ Swollen, reddened or sticky eyelids	
	____ Bags or dark circles under eyes	
	____ Blurred or tunnel vision	
	(not including near or far sightedness)	**Total ____**
HEAD	____ Headaches	
	____ Faintness	
	____ Dizziness	
	____ Insomnia	**Total ____**
HEART	____ Irregular or skipped heartbeat	
	____ Rapid or pounding heartbeat	
	____ Chest pain	**Total ____**

(Over, more on back)

JOINTS/MUSCLES	____ Pain or aches in joints	
	____ Arthritis	
	____ Stiffness or limitation of movement	
	____ Pain or aches in muscles	
	____ Feeling of weakness or tiredness	**Total ____**
LUNGS	____ Chest congestion	
	____ Asthma, bronchitis	
	____ Shortness of breath	
	____ Difficulty breathing	**Total ____**
MIND	____ Poor memory	
	____ Confusion, poor comprehension	
	____ Poor concentration	
	____ Poor physical coordination	
	____ Difficulty in making decisions	
	____ Stuttering or stammering	
	____ Slurred speech	
	____ Learning disabilities	**Total ____**
MOUTH/THROAT	____ Chronic coughing	
	____ Gagging, frequent need to clear throat	
	____ Sore throat, hoarseness, loss of voice	
	____ Swollen or discolored tongue, gums, lips	
	____ Canker sores	**Total ____**
NOSE	____ Stuffy nose	
	____ Sinus problems	
	____ Hay fever	
	____ Sneezing attacks	
	____ Excessive mucus formation	**Total ____**
SKIN	____ Acne	
	____ Hives, rashes, or dry skin	
	____ Hair loss	
	____ Flushing or hot flashes	
	____ Excessive sweating	**Total ____**
WEIGHT	____ Binge eating/drinking	
	____ Craving certain foods	
	____ Excessive weight	
	____ Compulsive eating	
	____ Water retention	
	____ Underweight	**Total ____**
OTHER	____ Frequent illness	
	____ Frequent or urgent urination	
	____ Genital itch or discharge	**Total ____**
		Grand Total