

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*

<i>DIGESTIVE TRACT</i>	<input type="checkbox"/> Nausea or vomiting	
	<input type="checkbox"/> Diarrhea	
	<input type="checkbox"/> Constipation	
	<input type="checkbox"/> Bloating Feeling	
	<input type="checkbox"/> Belching, or passing gas	
	<input type="checkbox"/> Heartburn	Total _____
<i>EARS</i>	<input type="checkbox"/> Itchy ears	
	<input type="checkbox"/> Ear aches, ear infections	
	<input type="checkbox"/> Drainage from ear	
	<input type="checkbox"/> Ringing in ears, hearing loss	Total _____
<i>EMOTIONS</i>	<input type="checkbox"/> Mood swings	
	<input type="checkbox"/> Anxiety, fear or nervousness	
	<input type="checkbox"/> Anger, irritability, or aggressiveness	
	<input type="checkbox"/> Depression	Total _____
<i>ENERGY/ACTIVITY</i>	<input type="checkbox"/> Fatigue, sluggishness	
	<input type="checkbox"/> Apathy, lethargy	
	<input type="checkbox"/> Hyperactivity	
	<input type="checkbox"/> Restlessness	Total _____
<i>EYES</i>	<input type="checkbox"/> Watery or itchy eyes	
	<input type="checkbox"/> Swollen, reddened or sticky eyelids	
	<input type="checkbox"/> Bags or dark circles under eyes	
	<input type="checkbox"/> Blurred or tunnel vision	
	(not including near or far sightedness)	Total _____
<i>HEAD</i>	<input type="checkbox"/> Headaches	
	<input type="checkbox"/> Faintness	
	<input type="checkbox"/> Dizziness	
	<input type="checkbox"/> Insomnia	Total _____
<i>HEART</i>	<input type="checkbox"/> Irregular or skipped heartbeat	
	<input type="checkbox"/> Rapid or pounding heartbeat	
	<input type="checkbox"/> Chest pain	Total _____

(Over, more on back)

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

Grand Total _____