

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 _____