Dr. Richard E. Picard
Advanced Nutrition

Patient Name _____ Date _____ File # _____

Metabolic Screening Questionnaire

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

0 = No Symptoms 1= Occasional 3= Frequent 5 = Always or 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
_____ Blocked/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 sores 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
_____ Speech dysfunction
_____ Difficulty learning 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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