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BOVAHEALTHANDWELLNESS.COM

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Date of Birth: _____ Sex: _____ Referred by: _____

METABOLIC ASSESSMENT

PART 1

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any recent traumas or severe stressors prompting symptoms? If so, please describe.

PART II

Please circle the appropriate number of all questions below. 0 as the least/never to 3 the most/always.

CATEGORY I

Feeling the bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

CATEGORY II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3
Abdominal intolerance to sugars and starches	0 1 2 3

CATEGORY III

Intolerance to smells	0 1 2 3
Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc.	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

CATEGORY IV

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables or undigested food found in stools	0 1 2 3

CATEGORY V

Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use antacids	
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

CATEGORY VI

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool, undigested, foul smelling, mucus-like, greasy or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3

CATEGORY VII

Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burpy, fishy taste after consuming fish oils	0 1 2 3
Difficulty losing weight	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	Yes No

CATEGORY VIII

Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalanced	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

CATEGORY IX

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory/forgetful	0 1 2 3
Blurred vision	0 1 2 3

CATEGORY X

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve craving for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

CATEGORY XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

CATEGORY XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

CATEGORY XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscles cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

CATEGORY XIV

Tired/sluggish				
Feel cold — hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3

CATEGORY XIV (Cont'd)

Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin/and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

CATEGORY XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

CATEGORY XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

CATEGORY XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

CATEGORY XVIII (Males Only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

CATEGORY XIX (Males Only)

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

CATEGORY XX (Menstruating Females Only)

Peri-menopausal	0	1	2	3
Alternating menstrual cycle lengths	0	1	2	3
Extended menstrual cycle (greater than 32 days)	0	1	2	3
Shortened menstrual cycle (less than 24 days)	0	1	2	3
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

CATEGORY XXI (Menopausal Females Only)

How many years have you been menopausal?	___	years		
Since menopause, do you ever have uterine bleeding	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

Please list what a normal day of eating looks like for you and at what time you typically eat. Please circle N/A when you do not eat a meal or snack.

Breakfast Time: N/A

Snack Time: N/A

Lunch Time: N/A

Snack Time: N/A

Dinner Time: N/A

Snack Time: N/A

Please list any other times you eat during the day and what you eat:

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

HISTORY & CURRENT CONCERNS

1. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(please circle one)*

2. Who else have you seen for your problem?

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER Physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> No One | <input type="checkbox"/> Other: _____ |

3. How long have you had your problem? _____

4. What aggravates your problem? _____

5. What concerns you the most about your problem? What does it prevent you from doing?

6. What is your: Height _____ Weight _____

Occupation _____

7. Please indicate any family members with the following diseases:

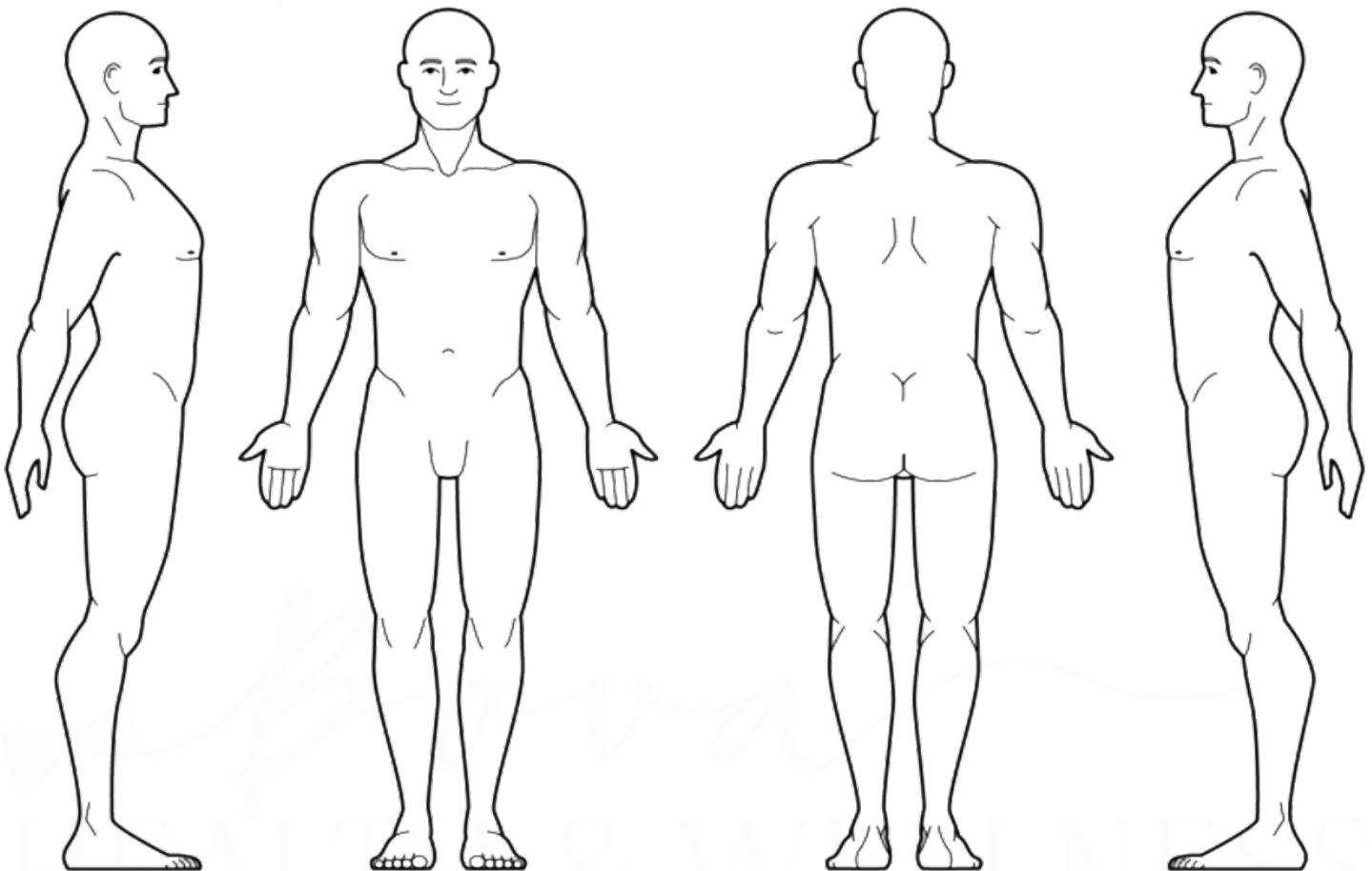
- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> MS | <input type="checkbox"/> Hypothyroid/Hashimoto's |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Colitis/IBS | <input type="checkbox"/> Other: _____ |

8. Do you currently suffer from any of these conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Angina | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Dermatitis/Eczema |
| <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Abnormal Weight Gain/Loss | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Ulcer | <input type="checkbox"/> General Fatigue |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Muscular In-coordination |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other: _____ | |

9. Indicate on the drawings below where you have pain/symptoms or check the box below:

N/A



10. List all surgical procedures you have had:

11. Have you ever been hospitalized? No Yes

If yes, why _____

12. *Females Only* – Please list any pregnancies, births, or complications:

Patient Signature: _____ Date: _____