Colonhydrotherapy
Metabolic Screening Questionnaire

Client Name:_____Date:_____

Rate each of the following symptoms based upon your typical health profile.

❑ INITIAL TEST ❑ RETEST- Initial Test Date _____

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

HEAD ____Headaches ____Faintness ____Dizziness ____Insomnia Total _____	MOUTH/THROAT ____Chronic coughing ____Gagging, frequent need to clear throat ____Sore throat, hoarseness, loss of voice ____Swollen or discolored tongue, gums or lips Total _____
EYES ____Watery or itchy eyes ____Swollen, reddened or sticky eyelids ____Bags or dark circles under eyes ____Blurred or tunnel vision Total _____	SKIN ____Acne ____Hives, rashes, dry skin ____Hair loss ____Flushing, hot flashes ____Excessive sweating Total _____
EARS ____Itchy Ears ____Earaches, ear infections ____Drainage from ear ____Ringing in ears, hearing loss Total _____	HEART ____Irregular or skipped heartbeat ____Rapid or pounding heartbeat ____Chest pain Total _____
NOSE ____Stuffy nose ____Sinus problems ____Hay fever ____Sneezing attacks ____Excessive mucus formation Total _____	LUNGS ____Chest congestion ____Asthma, bronchitis ____Shortness of breath ____Difficulty breathing Total _____

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, vomiting ____Diarrhea ____Constipated ____Bloated feeling ____Belching, passing gas ____Heartburn ____Intestinal/stomach pain Total _____	ENERGY/ACTIVITY ____Fatigue, sluggishness ____Apathy, lethargy ____Hyperactivity ____Restlessness Total _____
JOINTS/MUSCLES ____Pain or aches in joint ____Arthritis ____Stiffness or limitation of movement ____Pain or aches in muscles ____Feeling of weakness or tiredness Total _____	MINDS ____Poor memory ____Confusion, poor comprehension ____Poor concentration ____Difficulty in making decisions ____Stuttering or stammering ____Slurred speech ____Learning disabilities Total _____
WEIGHT ____Binge eating/drinking ____Craving certain foods ____Excessive weight ____Compulsive eating ____Water retention ____Underweight Total _____	EMOTIONS ____Mood swings ____Anxiety, fear, nervousness ____Anger, irritability, aggressiveness ____Depression Total _____
OTHER ____Frequent illness ____Frequent or urgent urination ____General itch or discharge Total _____	**GRAND TOTAL _____**

Notes:_____

_____

_____

_____