METABOLIC CLEARING THERAPY — TESTING SCALE (RETEST)

Name__________ Date__________ Total Score__________

Rate each of the following symptoms based upon your health profile for the past 48 hours.

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 or vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, or passing gas
____ Heartburn

Subtotal ____

EARS

____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing in ears, hearing loss

Subtotal ____

EMOTIONS

____ Mood swings
____ Anxiety, fear, or nervousness
____ Anger, irritability, or aggressiveness
____ Depression

Subtotal ____

ENERGY/ ACTIVITY

____ Fatigue, sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness

Subtotal ____

EYES

____ Watery or itchy eyes
____ Swollen, reddened, or sticky eyelids
____ Bags or dark circles under eyes
____ Blurred or tunnel vision
(does not include near- or far-sightedness)

Subtotal ____

HEAD

____ Headaches
____ Faintness
____ Dizziness
____ Insomnia

Subtotal ____

HEART

____ Irregular or skipped heartbeat
____ Rapid or pounding heartbeat
____ Chest pain

Subtotal ____

JOINTS/ MUSCLES

____ Pain or aches in joints
____ Arthritis
____ Stiffness or limitation of movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness

Subtotal ____

LUNGS

____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing

Subtotal ____

MIND

____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty in making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities

Subtotal ____

MOUTH/ THROAT

____ Chronic coughing
____ Gagging, frequent need to clear throat
____ Sore throat, hoarseness, loss of voice
____ Swollen or discolored tongue, gums, lips
____ Canker sores

Subtotal ____

NOSE

____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucus formation

Subtotal ____

SKIN

____ Acne
____ Hives, rashes, or dry skin
____ Hair loss
____ Flushing or hot flashes
____ Excessive sweating

Subtotal ____

WEIGHT

____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight

Subtotal ____

OTHER

____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge

Subtotal ____

TOTAL SCORE: ____