



## Metabolic Clearing Therapy - initial testing scale

THIS IS A USEFUL SELF ASSESEMENT OF ONE'S DETOXIFICATION FUNCTION BASED ON SYMPTOMS. A SCORE OF 50 OR MORE OR A SCORE OF 10 OR MORE IN ANY 1 SECTION INDICATES THE NEED TO UP-REGULATE YOUR DETOXIFICATION FUNCTION.

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

<b>Digestive Tract:</b> <input type="checkbox"/> nausea or vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> bloated feeling <input type="checkbox"/> belching or passing gas <input type="checkbox"/> heartburn	Total: <input type="text"/>	<b>Eyes:</b> <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 (does not include near or far sightedness)	Total: <input type="text"/>
<b>Ears:</b> <input type="checkbox"/> itchy ears <input type="checkbox"/> earaches, ear infections <input type="checkbox"/> drainage from ear <input type="checkbox"/> ringing in ears, hearing loss	Total: <input type="text"/>	<b>Head:</b> <input type="checkbox"/> headaches <input type="checkbox"/> faintness <input type="checkbox"/> dizziness <input type="checkbox"/> insomnia	Total: <input type="text"/>
<b>Emotions:</b> <input type="checkbox"/> mood swings <input type="checkbox"/> anxiety, fear or nervousness <input type="checkbox"/> anger, irritability or aggressiveness <input type="checkbox"/> depression	Total: <input type="text"/>	<b>Heart:</b> <input type="checkbox"/> irregular or skipped heartbeat <input type="checkbox"/> rapid or pounding heartbeat <input type="checkbox"/> chest pain	Total: <input type="text"/>
<b>Energy/Activity:</b> <input type="checkbox"/> fatigue, sluggishness <input type="checkbox"/> apathy, lethargy <input type="checkbox"/> hyperactivity <input type="checkbox"/> restlessness	Total: <input type="text"/>	<b>Joints/Muscles:</b> <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: <input type="text"/>



<b>Lungs:</b>  <input type="checkbox"/> chest congestion <input type="checkbox"/> asthma, bronchitis <input type="checkbox"/> shortness of breath <input type="checkbox"/> difficulty breathing	<b>Total:</b>	<b>Nose:</b>  <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	<b>Total:</b>
<b>Mind:</b>  <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	<b>Total:</b>	<b>Skin:</b>  <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	<b>Total:</b>
<b>Mouth/Throat:</b>  <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 of lips <input type="checkbox"/> canker sores	<b>Total:</b>	<b>Weight:</b>  <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	<b>Total:</b>
		<b>Other:</b>  <input type="checkbox"/> frequent illness <input type="checkbox"/> frequent or urgent urination <input type="checkbox"/> genital itch or discharge	<b>Total:</b>
<b>Grand total:</b>			