Metabolic Clearing Therapy Initial Testing Scale

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

0 = Never or almost never have the symptom
1 = Occasionally have it, effect not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect not severe
4 = Frequently have it, effect is severe

			Totals
Digestive Tract	____ ____ ____ ____ ____ ____	Nausea or vomiting Diarrhoea Constipation Bloated feeling Belching or passing gas Heartburn	_____
Ears	____ ____ ____ ____	Itchy ears Earaches/infections Drainage from ear Ringing in ears, hearing loss	_____
Emotions	____ ____ ____ ____	Mood swings Anxiety fear or nervousness Anger, irritability or aggressiveness Depression	_____
Energy/ Activity	____ ____ ____ ____	Fatigue, sluggishness Apathy, lethargy Hyperactivity Restlessness	_____
Eyes	____ ____ ____ ____	Watery or itchy Swollen, reddened or sticky eyelids Bags or dark circles under eyes Blurred or tunnel vision (does not include near or far sightedness)	_____
Head	____ ____ ____ ____	Headaches Faintness Dizziness Insomnia	_____
Heart	____ ____ ____	Irregular or skipped heartbeat Rapid or pounding heartbeat Chest pain	_____

			Totals
Joints/Muscles	_____ _____ _____ _____ _____	Pain or aches in joints Arthritis Stiffness or limitation of movement Pain or aches in muscles Feeling of weakness or tiredness	_____
Lungs	_____ _____ _____ _____	Chest congestion Asthma, bronchitis Shortness of breath Difficulty breathing	_____
Mind	_____ _____ _____ _____ _____ _____ _____ _____	Poor memory Confusion, poor comprehension Poor concentration Poor physical coordination Difficulty in making decisions Stuttering or stammering Slurred speech Learning disabilities	_____
Mouth/Throat	_____ _____ _____ _____ _____	Chronic coughing Gagging, frequent need to clear throat Sore throat, hoarsness, loss of voice Swollen or discoloured tongue, gums, lips Canker cores	_____
Nose	_____ _____ _____ _____ _____	Stuffy nose Sinus problems Hay fever Sneezing attacks Excessive mucus formation	_____
Skin	_____ _____ _____ _____ _____	Acne Hives or rashes or dry skin Hair loss Flushing or hot flushes Excessive sweating	_____
Weight	_____ _____ _____ _____ _____ _____	Binge eating/drinking Craving certain foods Excessive weight Compulsive eating Water retention Underweight	_____
Other	_____ _____ _____	Frequent illness Frequent or urgent urination General itch or discharge	_____