

SYMPTOM SURVEY FORM



Patient _____ Doctor _____ Date _____

Birth Date ____ / ____ / ____ Approx Weight _____ Vegetarian: Yes .. No ..

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

* Fill in the circle marked 1 for MILD symptoms (occurred once or twice last 6 months). ●○○

* Fill in the circle marked 2 for MODERATE symptoms (occurred once or twice last month). ○●○

* Fill in the circle marked 3 for SEVERE symptoms (chronic, occurred once or twice last week). ○○●

Leave circles BLANK if they don't apply to you! ○○○

GROUP 1

- | | | |
|---|--|--|
| <p>1 2 3</p> <p>1 ○○○○ Acid foods upset</p> <p>2 ○○○○ Get chilled often</p> <p>3 ○○○○ "Lump" in throat</p> <p>4 ○○○○ Dry mouth-eyes-nose</p> <p>5 ○○○○ Pulse speeds after meal</p> <p>6 ○○○○ Keyed up - fail to calm</p> <p>7 ○○○○ Cut heals slowly</p> | <p>1 2 3</p> <p>8 ○○○○ Gag easily</p> <p>9 ○○○○ Unable to relax; startles easily</p> <p>10 ○○○○ Extremities cold, clammy</p> <p>11 ○○○○ Strong light irritates</p> <p>12 ○○○○ Urine amount reduced</p> <p>13 ○○○○ Heart pounds after retiring</p> <p>14 ○○○○ "Nervous" stomach</p> | <p>1 2 3</p> <p>15 ○○○○ Appetite reduced</p> <p>16 ○○○○ Cold sweats often</p> <p>17 ○○○○ Fever easily raised</p> <p>18 ○○○○ Neuralgia-like pains</p> <p>19 ○○○○ Staring, blinks little</p> <p>20 ○○○○ Sour stomach often</p> |
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GROUP 2

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| <p>1 2 3</p> <p>21 ○○○○ Joint stiffness on arising</p> <p>22 ○○○○ Muscle-leg-toe cramps at night</p> <p>23 ○○○○ "Butterfly" stomach, cramps</p> <p>24 ○○○○ Eyes or nose watery</p> <p>25 ○○○○ Eyes blink often</p> <p>26 ○○○○ Eyelids swollen, puffy</p> <p>27 ○○○○ Indigestion soon after meals</p> <p>28 ○○○○ Always seems hungry; feels "lightheaded" often</p> | <p>1 2 3</p> <p>29 ○○○○ Digestion rapid</p> <p>30 ○○○○ Vomiting frequent</p> <p>31 ○○○○ Hoarseness frequent</p> <p>32 ○○○○ Breathing irregular</p> <p>33 ○○○○ Pulse slow; feels "irregular"</p> <p>34 ○○○○ Gagging reflex slow</p> <p>35 ○○○○ Difficulty swallowing</p> <p>36 ○○○○ Constipation, diarrhea alternating</p> | <p>1 2 3</p> <p>37 ○○○○ "Slow starter"</p> <p>38 ○○○○ Get "chilled" infrequently</p> <p>39 ○○○○ Perspire easily</p> <p>40 ○○○○ Circulation poor, sensitive to cold</p> <p>41 ○○○○ Subject to colds, asthma, bronchitis</p> |
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GROUP 3

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| <p>1 2 3</p> <p>42 ○○○○ Eat when nervous</p> <p>43 ○○○○ Excessive appetite</p> <p>44 ○○○○ Hungry between meals</p> <p>45 ○○○○ Irritable before meals</p> <p>46 ○○○○ Get "shaky" if hungry</p> <p>47 ○○○○ Fatigue, eating relieves</p> <p>48 ○○○○ "Lightheaded" if meals delayed</p> | <p>1 2 3</p> <p>49 ○○○○ Heart palpitates if meals missed or delayed</p> <p>50 ○○○○ Afternoon headaches</p> <p>51 ○○○○ Overeating sweets upsets</p> <p>52 ○○○○ Awaken after few hours sleep - hard to get back to sleep</p> | <p>1 2 3</p> <p>53 ○○○○ Crave candy or coffee in afternoons</p> <p>54 ○○○○ Moods of depression - "blues" or melancholy</p> <p>55 ○○○○ Abnormal craving for sweets or snacks</p> |
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GROUP 4

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| <p>1 2 3</p> <p>56 ○○○○ Hands and feet go to sleep easily, numbness</p> <p>57 ○○○○ Sigh frequently, "air hunger"</p> <p>58 ○○○○ Aware of "breathing heavily"</p> <p>59 ○○○○ High altitude discomfort</p> <p>60 ○○○○ Opens windows in closed rooms</p> <p>61 ○○○○ Susceptible to colds and fevers</p> <p>62 ○○○○ Afternoon "yawner"</p> | <p>1 2 3</p> <p>63 ○○○○ Get "drowsy" often</p> <p>64 ○○○○ Swollen ankles, worse at night</p> <p>65 ○○○○ Muscle cramps, worse during exercise; get "charley horses"</p> <p>66 ○○○○ Shortness of breath on exertion</p> <p>67 ○○○○ Dull pain in chest or radiating into left arm, worse on exertion</p> | <p>1 2 3</p> <p>68 ○○○○ Bruise easily, "black and blue" spots</p> <p>69 ○○○○ Tendency to anemia</p> <p>70 ○○○○ "Nose bleeds" frequent</p> <p>71 ○○○○ Noises in head, or "ringing in ears"</p> <p>72 ○○○○ Tension under the breastbone, or feeling of "tightness", worse on exertion</p> |
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SYMPTOM SURVEY FORM - PAGE 2

GROUP 5

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|--|---|---|
| <p>1 2 3</p> <p>73 ○○○ Dizziness</p> <p>74 ○○○ Dry skin</p> <p>75 ○○○ Burning feet</p> <p>76 ○○○ Blurred vision</p> <p>77 ○○○ Itching skin and feet</p> <p>78 ○○○ Excessive falling hair</p> <p>79 ○○○ Frequent skin rashes</p> <p>80 ○○○ Bitter, metallic taste in mouth in mornings</p> <p>81 ○○○ Bowel movements painful or difficult</p> <p>82 ○○○ Worrier, feels insecure</p> | <p>1 2 3</p> <p>83 ○○○ Feeling queasy; headache over eyes</p> <p>84 ○○○ Greasy foods upset</p> <p>85 ○○○ Stools light colored</p> <p>86 ○○○ Skin peels on foot soles</p> <p>87 ○○○ Pain between shoulder blades</p> <p>88 ○○○ Use laxatives</p> <p>89 ○○○ Stools alternate from soft to watery</p> <p>90 ○○○ History of gallbladder attacks or gallstones</p> | <p>1 2 3</p> <p>91 ○○○ Sneezing attacks</p> <p>92 ○○○ Dreaming, nightmare type bad dreams</p> <p>93 ○○○ Bad breath (halitosis)</p> <p>94 ○○○ Milk products cause distress</p> <p>95 ○○○ Sensitive to hot weather</p> <p>96 ○○○ Burning or itching anus</p> <p>97 ○○○ Crave sweets</p> |
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GROUP 6

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| <p>1 2 3</p> <p>98 ○○○ Loss of taste for meat</p> <p>99 ○○○ Lower bowel gas several hours after eating</p> <p>100 ○○○ Burning stomach sensations, eating relieves</p> | <p>1 2 3</p> <p>101 ○○○ Coated tongue</p> <p>102 ○○○ Pass large amounts of foul-smelling gas</p> <p>103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.</p> | <p>1 2 3</p> <p>104 ○○○ Mucous colitis or "irritable bowel"</p> <p>105 ○○○ Gas shortly after eating</p> <p>106 ○○○ Stomach "bloating" after</p> |
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GROUP 7

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| <p>(A)</p> <p>1 2 3</p> <p>107 ○○○ Insomnia</p> <p>108 ○○○ Nervousness</p> <p>109 ○○○ Can't gain weight</p> <p>110 ○○○ Intolerance to heat</p> <p>111 ○○○ Highly emotional</p> <p>112 ○○○ Flush easily</p> <p>113 ○○○ Night sweats</p> <p>114 ○○○ Thin, moist skin</p> <p>115 ○○○ Inward trembling</p> <p>116 ○○○ Heart palpitates</p> <p>117 ○○○ Increased appetite without weight gain</p> <p>118 ○○○ Pulse fast at rest</p> <p>119 ○○○ Eyelids and face twitch</p> <p>120 ○○○ Irritable and restless</p> <p>121 ○○○ Can't work under pressure</p> | <p>(C)</p> <p>1 2 3</p> <p>137 ○○○ Failing memory</p> <p>138 ○○○ Low blood pressure</p> <p>139 ○○○ Increased sex drive</p> <p>140 ○○○ Headaches, "splitting or rending" type</p> <p>141 ○○○ Decreased sugar tolerance</p> <p>(D)</p> <p>1 2 3</p> <p>142 ○○○ Abnormal thirst</p> <p>143 ○○○ Bloating of abdomen</p> <p>144 ○○○ Weight gain around hips or waist</p> <p>145 ○○○ Sex drive reduced or lacking</p> <p>146 ○○○ Tendency to ulcers, colitis</p> <p>147 ○○○ Increased sugar tolerance</p> <p>148 ○○○ Women: menstrual disorders</p> <p>149 ○○○ Young girls: lack of menstrual function</p> | <p>(E)</p> <p>1 2 3</p> <p>150 ○○○ Dizziness</p> <p>151 ○○○ Headaches</p> <p>152 ○○○ Hot flashes</p> <p>153 ○○○ Increased blood pressure</p> <p>154 ○○○ Hair growth on face or body (female)</p> <p>155 ○○○ Sugar in urine (not diabetes)</p> <p>156 ○○○ Masculine tendencies (female)</p> <p>(F)</p> <p>1 2 3</p> <p>157 ○○○ Weakness, dizziness</p> <p>158 ○○○ Chronic fatigue</p> <p>159 ○○○ Low blood pressure</p> <p>160 ○○○ Nails weak, ridged</p> <p>161 ○○○ Tendency to hives</p> <p>162 ○○○ Arthritic tendencies</p> <p>163 ○○○ Perspiration increase</p> <p>164 ○○○ Bowel disorders</p> <p>165 ○○○ Poor circulation</p> <p>166 ○○○ Swollen ankles</p> <p>167 ○○○ Crave salt</p> <p>168 ○○○ Brown spots or bronzing of skin</p> <p>169 ○○○ Allergies - tendency to asthma</p> <p>170 ○○○ Weakness after colds, influenza</p> <p>171 ○○○ Exhaustion - muscular and nervous</p> <p>172 ○○○ Respiratory disorders</p> |
| <p>(B)</p> <p>1 2 3</p> <p>122 ○○○ Increase in weight</p> <p>123 ○○○ Decrease in appetite</p> <p>124 ○○○ Fatigue easily</p> <p>125 ○○○ Ringing in ears</p> <p>126 ○○○ Sleepy during day</p> <p>127 ○○○ Sensitive to cold</p> <p>128 ○○○ Dry or scaly skin</p> <p>129 ○○○ Constipation</p> <p>130 ○○○ Mental sluggishness</p> <p>131 ○○○ Hair coarse, falls out</p> <p>132 ○○○ Headaches upon arising, wear off during day</p> <p>133 ○○○ Slow pulse, below 65</p> <p>134 ○○○ Frequency of urination</p> <p>135 ○○○ Impaired hearing</p> <p>136 ○○○ Reduced initiative</p> | | |

SYMPTOM SURVEY FORM - PAGE 3

GROUP 8

<p>1 2 3</p> <p>173 ○○○ Apprehension</p> <p>174 ○○○ Irritability</p> <p>175 ○○○ Morbid fears</p> <p>176 ○○○ Never seems to get well</p> <p>177 ○○○ Forgetfulness</p> <p>178 ○○○ Indigestion</p> <p>179 ○○○ Poor appetite</p> <p>180 ○○○ Craving for sweets</p> <p>181 ○○○ Muscular soreness</p> <p>182 ○○○ Depression; feelings of dread</p>	<p>1 2 3</p> <p>183 ○○○ Noise sensitivity</p> <p>184 ○○○ Acoustic hallucinations</p> <p>185 ○○○ Tendency to cry without reason</p> <p>186 ○○○ Hair is coarse and/or thinning</p> <p>187 ○○○ Weakness</p> <p>188 ○○○ Fatigue</p> <p>189 ○○○ Skin sensitive to touch</p> <p>190 ○○○ Tendency toward hives</p> <p>191 ○○○ Nervousness</p> <p>192 ○○○ Headache</p>	<p>1 2 3</p> <p>193 ○○○ Insomnia</p> <p>194 ○○○ Anxiety</p> <p>195 ○○○ Anorexia</p> <p>196 ○○○ Inability to concentrate; confusion</p> <p>197 ○○○ Frequent stuffy nose; sinus infections</p> <p>198 ○○○ Allergy to some foods</p> <p>199 ○○○ Loose joints</p>
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FEMALE ONLY

<p>1 2 3</p> <p>200 ○○○ Very easily fatigued</p> <p>201 ○○○ Premenstrual tension</p> <p>202 ○○○ Painful menses</p> <p>203 ○○○ Depressed feelings before menstruation</p> <p>204 ○○○ Menstruation excessive and prolonged</p> <p>205 ○○○ Painful breasts</p>	<p>1 2 3</p> <p>206 ○○○ Menstruate too frequently</p> <p>207 ○○○ Vaginal discharge</p> <p>208 ○ Hysterectomy / ovaries removed</p> <p>209 ○○○ Menopausal hot flashes</p> <p>210 ○○○ Menses scanty or missed</p> <p>211 ○○○ Acne, worse at menses</p> <p>212 ○○○ Depression of long standing</p>
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MALE ONLY

1 2 3

213 ○○○ Prostate trouble

214 ○○○ Urination difficult or dribbling

215 ○○○ Night urination frequent

216 ○○○ Depression

217 ○○○ Pain on inside of legs or heels

218 ○○○ Feeling of incomplete bowel evacuation

219 ○○○ Lack of energy

220 ○○○ Migrating aches and pains

221 ○○○ Tire too easily

222 ○○○ Avoids activity

223 ○○○ Leg nervousness at night

224 ○○○ Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. _____

2. _____

3. _____

4. _____

5. _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row

MALES

Any 2 days during the month

SYMPTOM SURVEY FORM - PAGE 4

Please list any medications you are taking:

No Medications

Please list any vitamins, herbs, or supplements you are taking:

No Vitamins

Please list any allergies you have:

No Allergies

Please list any surgeries you have had in the past 12 months:

No Recent Surgeries

Please list any other surgeries or medical procedures you have had:

No Other Surgeries

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

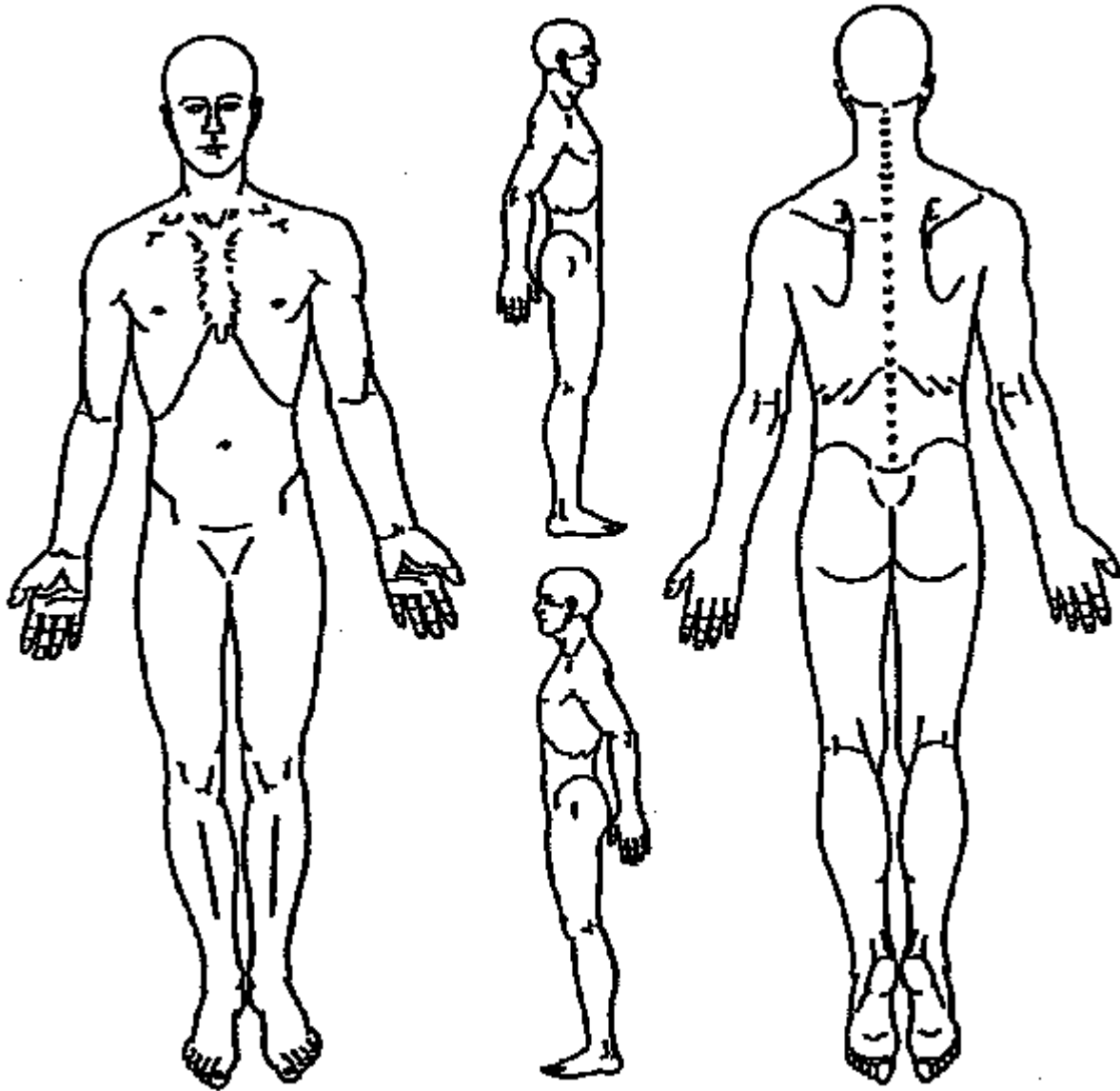
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYMPTOM SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____