

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 ONE

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| <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 TWO

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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 THREE

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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 FOUR

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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 FIVE

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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 SIX

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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 SEVEN

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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>(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>(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> | <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>(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> |

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 _____