

## SYMPTOM SURVEY FORM

Patient \_\_\_\_\_ Doctor \_\_\_\_\_ Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Approx Weight \_\_\_\_\_ Vegetarian: Yes  No

**INSTRUCTIONS:** Number only the boxes which apply to you. Leave blank if you don't have the problem.

\* Write 1 in the box for MILD symptoms (occurred once or twice last 6 months).

\* Write 2 in the box for MODERATE symptoms (occurred once or twice last month).

\* Write 3 in the box for SEVERE symptoms (chronic, occurred once or twice last week).

**Please do not use checkmarks in the boxes - fill in the boxes with a number or leave blank!**

### GROUP ONE

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

### GROUP TWO

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

### GROUP THREE

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

### GROUP FOUR

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

GROUP FIVE

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

GROUP SIX

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

GROUP SEVEN

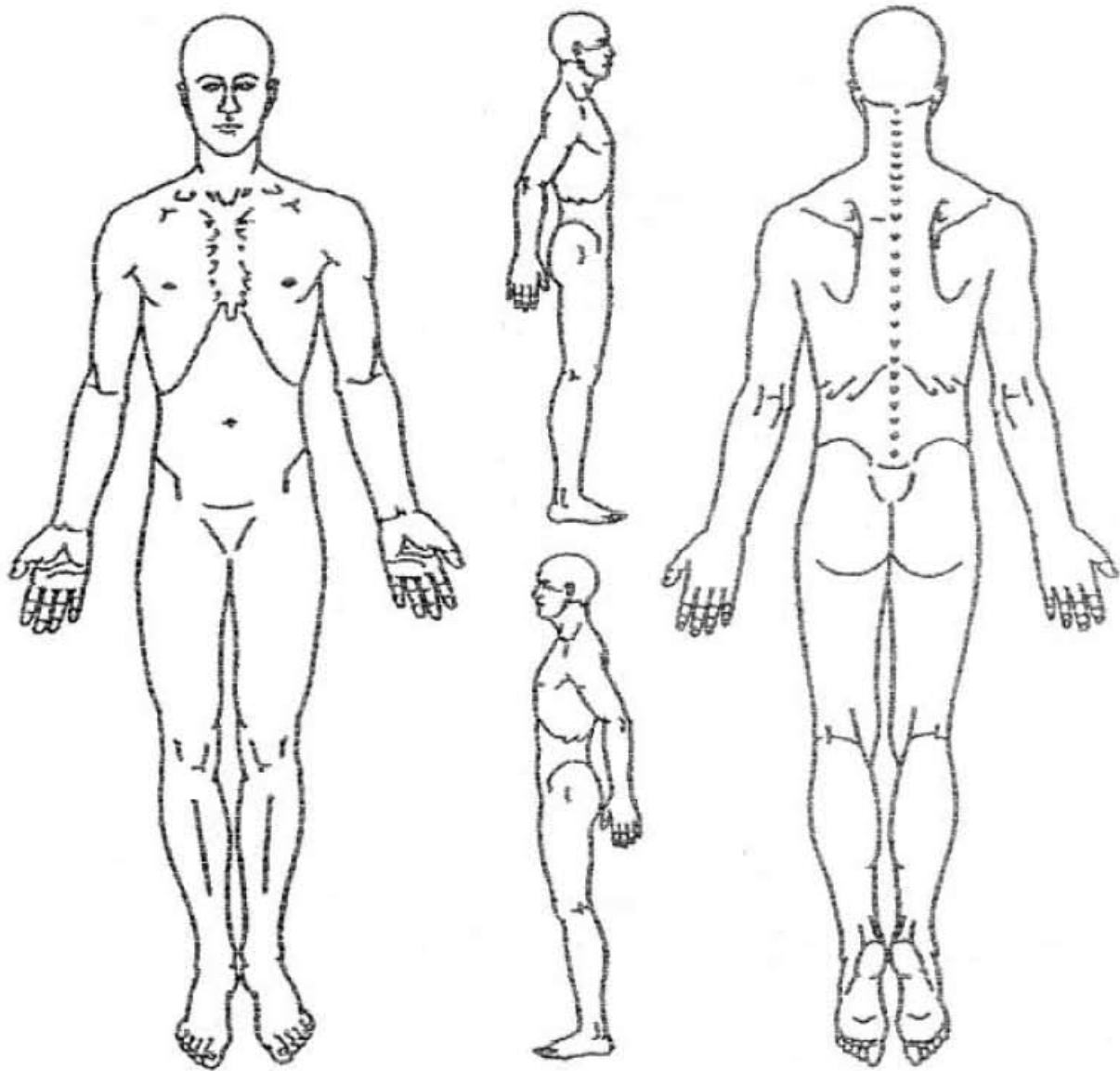
- |  |  |  |
|--|--|--|
| <p><b>(A)</b></p> <p>107 <input type="checkbox"/> Insomnia</p> <p>108 <input type="checkbox"/> Nervousness</p> <p>109 <input type="checkbox"/> Can't gain weight</p> <p>110 <input type="checkbox"/> Intolerance to heat</p> <p>111 <input type="checkbox"/> Highly emotional</p> 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



# SYMPTOM SURVEY FORM - PAGE 4

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 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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 \_\_\_\_\_