

Name: _____ Today's Date _____

Symptom Survey

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice a year), (2) for MODERATE symptoms (occur several times a year), and (3) for SEVERE symptoms (you are aware of it almost constantly).

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 frequent |
| 7 <input type="checkbox"/> | Cuts heal slowly | 14 <input type="checkbox"/> | "Nervous" stomach | | |

GROUP TWO

- | | | | | | |
|-----------------------------|--|-----------------------------|------------------------------------|-----------------------------|--------------------------------------|
| 21 <input type="checkbox"/> | Joint stiffness after 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 room | 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

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

SYMPTOM SURVEY FORM - Page 3

FEMALE ONLY

- | | | | |
|------------------------------|--|------------------------------|------------------------------|
| 173 <input type="checkbox"/> | Very easily fatigued | 181 <input type="checkbox"/> | Hysterectomy/ovaries removed |
| 174 <input type="checkbox"/> | Premenstrual tension | 182 <input type="checkbox"/> | Menopausal hot flashes |
| 175 <input type="checkbox"/> | Painful menses | 183 <input type="checkbox"/> | Menses scanty or missed |
| 176 <input type="checkbox"/> | Depressed feelings before menstruation | 184 <input type="checkbox"/> | Acne, worse at menses |
| 177 <input type="checkbox"/> | Menstruation excessive and prolonged | 185 <input type="checkbox"/> | Depression of long standing |
| 178 <input type="checkbox"/> | Painful breasts | | |
| 179 <input type="checkbox"/> | Menstruate too frequently | | |
| 180 <input type="checkbox"/> | Vaginal discharge | | |

MALE ONLY

- 186 Prostate trouble
- 187 Urination difficult or dribbling
- 188 Night urination frequent
- 189 Depression
- 190 Pain on inside of legs or heels
- 191 Feeling of incomplete bowel evacuation
- 192 Lack of energy
- 193 Migrating aches and pains
- 194 Tire too easily
- 195 Avoids activity
- 196 Leg nervousness at night
- 197 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

RECOMMENDATIONS AND SUMMARY:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

CASE RECORD

Name _____ Date _____ Home Phone (_____) _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Weight _____ Height _____ Sex _____

Occupation: _____ S.S.# _____ Married _____

History of Illness and Treatment _____

Operations, Accidents or Injuries: _____

Present Illness or Complaints: _____

Diagnostic Summary: _____

Treatment, Recommendations, and Progress: _____