

SYSTEMS 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 (occurs rarely).

* Write 2 in the box for MODERATE symptoms (occurs several times a month).

* Write 3 in the box for SEVERE symptoms (occurs almost constantly).

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

GROUP 1

- | | | |
|--|---|--|
| 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 2

- | | | |
|--|--|--|
| 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 3

- | | | |
|--|--|---|
| 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 4

- | | | |
|---|--|--|
| 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" | | |

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

- | | | |
|---|--|---|
| 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 6

- | | | |
|--|---|--|
| 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 7

(A)

- 107 ☐ Insomnia
 108 ☐ Nervousness
 109 ☐ Can't gain weight
 110 ☐ Intolerance to heat
 111 ☐ Highly emotional
 112 ☐ Flush easily
 113 ☐ Night sweats
 114 ☐ Thin, moist skin
 115 ☐ Inward trembling
 116 ☐ Heart palpitates
 117 ☐ Increased appetite without weight gain
 118 ☐ Pulse fast at rest
 119 ☐ Eyelids and face twitch
 120 ☐ Irritable and restless
 121 ☐ Can't work under pressure

(B)

- 122 ☐ Increase in weight
 123 ☐ Decrease in appetite
 124 ☐ Fatigue easily
 125 ☐ Ringing in ears
 126 ☐ Sleepy during day
 127 ☐ Sensitive to cold
 128 ☐ Dry or scaly skin
 129 ☐ Constipation
 130 ☐ Mental sluggishness
 131 ☐ Hair coarse, falls out
 132 ☐ Headaches upon arising, wear off during day
 133 ☐ Slow pulse, below 65
 134 ☐ Frequency of urination
 135 ☐ Impaired hearing
 136 ☐ Reduced initiative

(C)

- 137 ☐ Failing memory
 138 ☐ Low blood pressure
 139 ☐ Increased sex drive
 140 ☐ Headaches, "splitting or rending" type
 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
 143 ☐ Bloating of abdomen
 144 ☐ Weight gain around hips or waist
 145 ☐ Sex drive reduced or lacking
 146 ☐ Tendency to ulcers, colitis
 147 ☐ Increased sugar tolerance
 148 ☐ Women: menstrual disorders
 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
 151 ☐ Headaches
 152 ☐ Hot flashes
 153 ☐ Increased blood pressure
 154 ☐ Hair growth on face or body (female)
 155 ☐ Sugar in urine (not diabetes)
 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
 158 ☐ Chronic fatigue
 159 ☐ Low blood pressure
 160 ☐ Nails weak, ridged
 161 ☐ Tendency to hives
 162 ☐ Arthritic tendencies
 163 ☐ Perspiration increase
 164 ☐ Bowel disorders
 165 ☐ Poor circulation
 166 ☐ Swollen ankles
 167 ☐ Crave salt
 168 ☐ Brown spots or bronzing of skin
 169 ☐ Allergies - tendency to asthma
 170 ☐ Weakness after colds, influenza
 171 ☐ Exhaustion - muscular and nervous
 172 ☐ Respiratory disorders

SYSTEMS SURVEY FORM - PAGE 3

-GROUP 8-

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

-FEMALE ONLY-

- | | | | | | |
|-----|--------------------------|--|-----|--------------------------|---|
| 200 | <input type="checkbox"/> | Very easily fatigued | 206 | <input type="checkbox"/> | Menstruate too frequently |
| 201 | <input type="checkbox"/> | Premenstrual tension | 207 | <input type="checkbox"/> | Vaginal discharge |
| 202 | <input type="checkbox"/> | Painful menses | 208 | <input type="checkbox"/> | Hysterectomy/ovaries removed (write number 3) |
| 203 | <input type="checkbox"/> | Depressed feelings before menstruation | 209 | <input type="checkbox"/> | Menopausal hot flashes |
| 204 | <input type="checkbox"/> | Menstruation excessive and prolonged | 210 | <input type="checkbox"/> | Menses scanty or missed |
| 205 | <input type="checkbox"/> | Painful breasts | 211 | <input type="checkbox"/> | Acne, worse at menses |
| | | | 212 | <input type="checkbox"/> | Depression of long standing |

-MALE ONLY

- 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.

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

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 _____

Date _____ Temperature _____

SYSTEMS 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 _____