

**SYMPTOM SURVEY FORM**  
(Restricted to Professional Use)

PATIENT \_\_\_\_\_ DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_

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).

<b>GROUP ONE</b>		
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	
<b>GROUP TWO</b>		
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	
<b>GROUP THREE</b>		
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		
<b>GROUP FOUR</b>		
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)  |   |
| 115 <input type="checkbox"/> Inward trembling                           | 142 <input type="checkbox"/> Abnormal thirst                         | (F)   |
| 116 <input type="checkbox"/> Heart palpitates                           | 143 <input type="checkbox"/> Bloating of abdomen                     | 157 <input type="checkbox"/> Weakness, dizziness                  |
| 117 <input type="checkbox"/> Increased appetite without weight gain     | 144 <input type="checkbox"/> Weight gain around hips or waist        | 158 <input type="checkbox"/> Chronic fatigue                      |
| 118 <input type="checkbox"/> Pulse fast at rest                         | 145 <input type="checkbox"/> Sex drive reduced or lacking            | 159 <input type="checkbox"/> Low blood pressure                   |
| 119 <input type="checkbox"/> Eyelids and face twitch                    | 146 <input type="checkbox"/> Tendency to ulcers, colitis             | 160 <input type="checkbox"/> Nails weak, ridged                   |
| 120 <input type="checkbox"/> Irritable and restless                     | 147 <input type="checkbox"/> Increased sugar tolerance               | 161 <input type="checkbox"/> Tendency to hives                    |
| 121 <input type="checkbox"/> Can't work under pressure                  | 148 <input type="checkbox"/> Women: menstrual disorders              | 162 <input type="checkbox"/> Arthritic tendencies                 |
| (B)   | 149 <input type="checkbox"/> Young girls: lack of menstrual function | 163 <input type="checkbox"/> Perspiration increase                |
| 122 <input type="checkbox"/> Increase in weight                         |  | 164 <input type="checkbox"/> Bowel disorders                      |
| 123 <input type="checkbox"/> Decrease in appetite                       |  | 165 <input type="checkbox"/> Poor circulation                     |
| 124 <input type="checkbox"/> Fatigue easily                             |  | 166 <input type="checkbox"/> Swollen ankles                       |
| 125 <input type="checkbox"/> Ringing in ears                            |  | 167 <input type="checkbox"/> Crave salt                           |
| 126 <input type="checkbox"/> Sleepy during day                          |  | 168 <input type="checkbox"/> Brown spots or bronzing of skin      |
| 127 <input type="checkbox"/> Sensitive to cold                          |  | 169 <input type="checkbox"/> Allergies - tendency to asthma       |
| 128 <input type="checkbox"/> Dry or scaly skin                          |  | 170 <input type="checkbox"/> Weakness after colds, influenza      |
| 129 <input type="checkbox"/> Constipation                               |  | 171 <input type="checkbox"/> Exhaustion - muscular and nervous    |
| 130 <input type="checkbox"/> Mental sluggishness                        |  | 172 <input type="checkbox"/> Respiratory disorders                |
| 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                         |  |   |

**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 \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_

Occupation: \_\_\_\_\_ Married \_\_\_\_\_

History of Illness and Treatment \_\_\_\_\_

Operations, Accidents or Injuries: \_\_\_\_\_

Present Illness or Complaints: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnostic Summary: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment, Recommendations, and Progress: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_