

SYMPTOM SURVEY FORM
(Restricted to Professional Use)

PATIENT _____ AGE _____ DOCTOR _____ DATE _____

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice a month), (2) for MODERATE symptoms (occur several times a month), 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 seem 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"		

SYMPTOM SURVEY FORM - Page 2

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 hours | 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 rendering" 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 | | |

SYMPTOM SURVEY FORM - Page 3

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 <input type="checkbox"/> Apprehension 174 <input type="checkbox"/> Irritability 175 <input type="checkbox"/> Morbid fears 176 <input type="checkbox"/> Never seems to get well 177 <input type="checkbox"/> Forgetfulness 178 <input type="checkbox"/> Indigestion 179 <input type="checkbox"/> Poor appetite 180 <input type="checkbox"/> Craving for sweets 181 <input type="checkbox"/> Muscular soreness 182 <input type="checkbox"/> Depression; feelings of dread 183 <input type="checkbox"/> Noise sensitivity 184 <input type="checkbox"/> Acoustic hallucinations 185 <input type="checkbox"/> Tendency to cry without reason 186 <input type="checkbox"/> Hair is coarse and/or thinning 187 <input type="checkbox"/> Weakness 188 <input type="checkbox"/> Fatigue 189 <input type="checkbox"/> Skin sensitive to touch 190 <input type="checkbox"/> Tendency toward hives 191 <input type="checkbox"/> Nervousness 192 <input type="checkbox"/> Headache 193 <input type="checkbox"/> Insomnia 194 <input type="checkbox"/> Anxiety 195 <input type="checkbox"/> Anorexia 196 <input type="checkbox"/> Inability to concentrate; confusion 197 <input type="checkbox"/> Frequent stuffy nose; sinus infections 198 <input type="checkbox"/> Allergy to some foods 199 <input type="checkbox"/> Loose joints	200 <input type="checkbox"/> Very easily fatigued 201 <input type="checkbox"/> Premenstrual tension 202 <input type="checkbox"/> Painful menses 203 <input type="checkbox"/> Depressed feelings before menstruation 204 <input type="checkbox"/> Menstruation excessive and prolonged 205 <input type="checkbox"/> Painful breasts 206 <input type="checkbox"/> Menstruate too frequently 207 <input type="checkbox"/> Vaginal discharge 208 <input type="checkbox"/> Hysterectomy/ovaries removed 209 <input type="checkbox"/> Menopausal hot flashes 210 <input type="checkbox"/> Menses scanty or missed 211 <input type="checkbox"/> Acne, worse at menses 212 <input type="checkbox"/> Depression of long standing	213 <input type="checkbox"/> Prostate trouble 214 <input type="checkbox"/> Urination difficult or dribbling 215 <input type="checkbox"/> Night urination frequent 216 <input type="checkbox"/> Depression 217 <input type="checkbox"/> Pain on inside of legs or heels 218 <input type="checkbox"/> Feeling of incomplete bowel evacuation 219 <input type="checkbox"/> Lack of energy 220 <input type="checkbox"/> Migrating aches and pains 221 <input type="checkbox"/> Tire too easily 222 <input type="checkbox"/> Avoids activity 223 <input type="checkbox"/> Leg nervousness at night 224 <input type="checkbox"/> 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 _____

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: _____

BP SIT _____ BP STAND _____
 PULSE SIT _____ PULSE STAND _____
 SALIVA PH _____ BLOOD TYPE _____

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: _____