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). 1 = Monthly
* Write 2 in the box for MODERATE symptoms (occurred once or twice last month). 2 = Weekly
* Write 3 in the box for SEVERE symptoms (chronic, occurred once or twice last week). 3 = Daily

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

GROUP 1

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

GROUP 2

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

GROUP 3

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

GROUP 4

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

SYMPTOM SURVEY FORM - PAGE 2

GROUP 5

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

GROUP 6

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

SYMPTOM SURVEY FORM - PAGE 3

GROUP 8

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

FEMALE ONLY

- 200 ☐ Very easily fatigued
- 201 ☐ Premenstrual tension
- 202 ☐ Painful menses
- 203 ☐ Depressed feelings before menstruation
- 204 ☐ Menstruation excessive and prolonged
- 205 ☐ Painful breasts
- 206 ☐ Menstruate too frequently
- 207 ☐ Vaginal discharge
- 208 ☐ Hysterectomy/ovaries removed (write number 3)
- 209 ☐ Menopausal hot flashes
- 210 ☐ Menses scanty or missed
- 211 ☐ Acne, worse at menses
- 212 ☐ 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	_____

SYMPTOM 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 _____

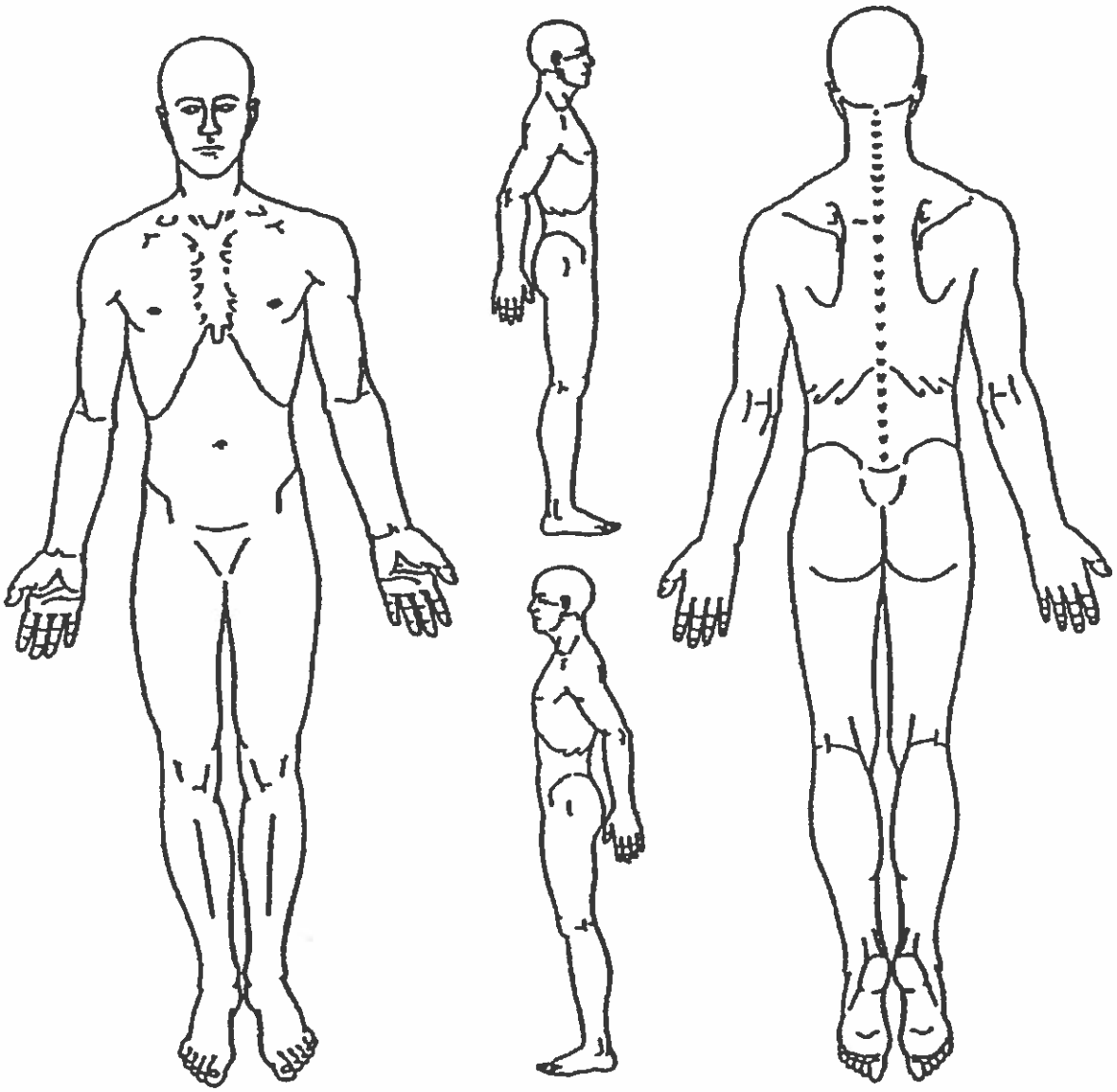
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYMPTOM SURVEY FORM - PAGE 5

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 SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____