

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____

Birth Date ____/____/____ Approx Weight _____ Vegetarian ☐ Gluten-free ☐

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

- Fill in the circle marked 1 for MILD symptoms (occurs rarely).
- Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
- Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
- **Leave circles BLANK if they don't apply to you!**

GROUP 1

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

GROUP 2

- | | | |
|---|---|---|
| 1 2 3
21 ○○○ Joint stiffness on arising | 1 2 3
29 ○○○ Digestion rapid | 1 2 3
37 ○○○ "Slow starter" |
| 22 ○○○ Muscle-leg-toe cramps at night | 30 ○○○ Vomiting frequent | 38 ○○○ Get "chilled" infrequently |
| 23 ○○○ "Butterfly" stomach, cramps | 31 ○○○ Hoarseness frequent | 39 ○○○ Perspire easily |
| 24 ○○○ Eyes or nose watery | 32 ○○○ Breathing irregular | 40 ○○○ Circulation poor, sensitive to cold |
| 25 ○○○ Eyes blink often | 33 ○○○ Pulse slow; feels "irregular" | 41 ○○○ Subject to colds, asthma, bronchitis |
| 26 ○○○ Eyelids swollen, puffy | 34 ○○○ Gagging reflex slow | |
| 27 ○○○ Indigestion soon after meals | 35 ○○○ Difficulty swallowing | |
| 28 ○○○ Always seems hungry; feels "lightheaded" often | 36 ○○○ Constipation, diarrhea alternating | |

GROUP 3

- | | | |
|---------------------------------------|---|---|
| 1 2 3
42 ○○○ Eat when nervous | 1 2 3
49 ○○○ Heart palpitates if meals missed or delayed | 1 2 3
53 ○○○ Crave candy or coffee in afternoons |
| 43 ○○○ Excessive appetite | 50 ○○○ Afternoon headaches | 54 ○○○ Moods of depression - "blues" or melancholy |
| 44 ○○○ Hungry between meals | 51 ○○○ Overeating sweets upsets | 55 ○○○ Abnormal craving for sweets or snacks |
| 45 ○○○ Irritable before meals | 52 ○○○ Awaken after few hours sleep - hard to get back to sleep | |
| 46 ○○○ Get "shaky" if hungry | | |
| 47 ○○○ Fatigue, eating relieves | | |
| 48 ○○○ "Lightheaded" if meals delayed | | |

GROUP 4

- | | | |
|---|---|---|
| 1 2 3
56 ○○○ Hands and feet go to sleep easily, numbness | 1 2 3
63 ○○○ Get "drowsy" often | 1 2 3
68 ○○○ Bruise easily, "black and blue" spots |
| 57 ○○○ Sigh frequently, "air hunger" | 64 ○○○ Swollen ankles, worse at night | 69 ○○○ Tendency to anemia |
| 58 ○○○ Aware of "breathing heavily" | 65 ○○○ Muscle cramps, worse during exercise; get "charley horses" | 70 ○○○ "Nose bleeds" frequent |
| 59 ○○○ High altitude discomfort | 66 ○○○ Shortness of breath on exertion | 71 ○○○ Noises in head, or "ringing in ears" |
| 60 ○○○ Opens windows in closed rooms | 67 ○○○ Dull pain in chest or radiating into left arm, worse on exertion | 72 ○○○ Tension under the breastbone, or feeling of "tightness", worse on exertion |
| 61 ○○○ Susceptible to colds and fevers | | |
| 62 ○○○ Afternoon "yawner" | | |

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

- 1 2 3
- 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

- 1 2 3
- 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

- 1 2 3
- 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

- 1 2 3
- 98 ☐ ☐ ☐ Loss of taste for meat
- 99 ☐ ☐ ☐ Lower bowel gas several hours after eating
- 100 ☐ ☐ ☐ Burning stomach sensations, eating relieves

- 1 2 3
- 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.

- 1 2 3
- 104 ☐ ☐ ☐ Mucous colitis or "irritable bowel"
- 105 ☐ ☐ ☐ Gas shortly after eating
- 106 ☐ ☐ ☐ Stomach "bloating" after

GROUP 7

- 1 2 3 (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

- 1 2 3 (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

- 1 2 3 (C)
- 137 ☐ ☐ ☐ Failing memory
- 138 ☐ ☐ ☐ Low blood pressure
- 139 ☐ ☐ ☐ Increased sex drive
- 140 ☐ ☐ ☐ Headaches, "splitting or rending" type
- 141 ☐ ☐ ☐ Decreased sugar tolerance

- 1 2 3 (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

- 1 2 3 (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)

- 1 2 3 (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-

[illegible]

-FEMALE ONLY-

	1	2	3			1	2	3		
200	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Very easily fatigued		206	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Menstruate too frequently
201	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Premenstrual tension		207	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vaginal discharge
202	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Painful menses		208	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hysterectomy / ovaries removed
203	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Depressed feelings before menstruation		209	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Menopausal hot flashes
204	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Menstruation excessive and prolonged		210	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Menses scanty or missed
205	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Painful breasts		211	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Acne, worse at menses
						212	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Depression of long standing

—MALE ONLY—

	1	2	3	
213	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prostate trouble
214	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Urination difficult or dribbling
215	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Night urination frequent
216	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Depression
217	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain on inside of legs or heels
218	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Feeling of incomplete bowel evacuation
219	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lack of energy
220	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Migrating aches and pains
221	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tire too easily
222	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Avoids activity
223	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Leg nervousness at night
224	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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.

[illegible]

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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 _____

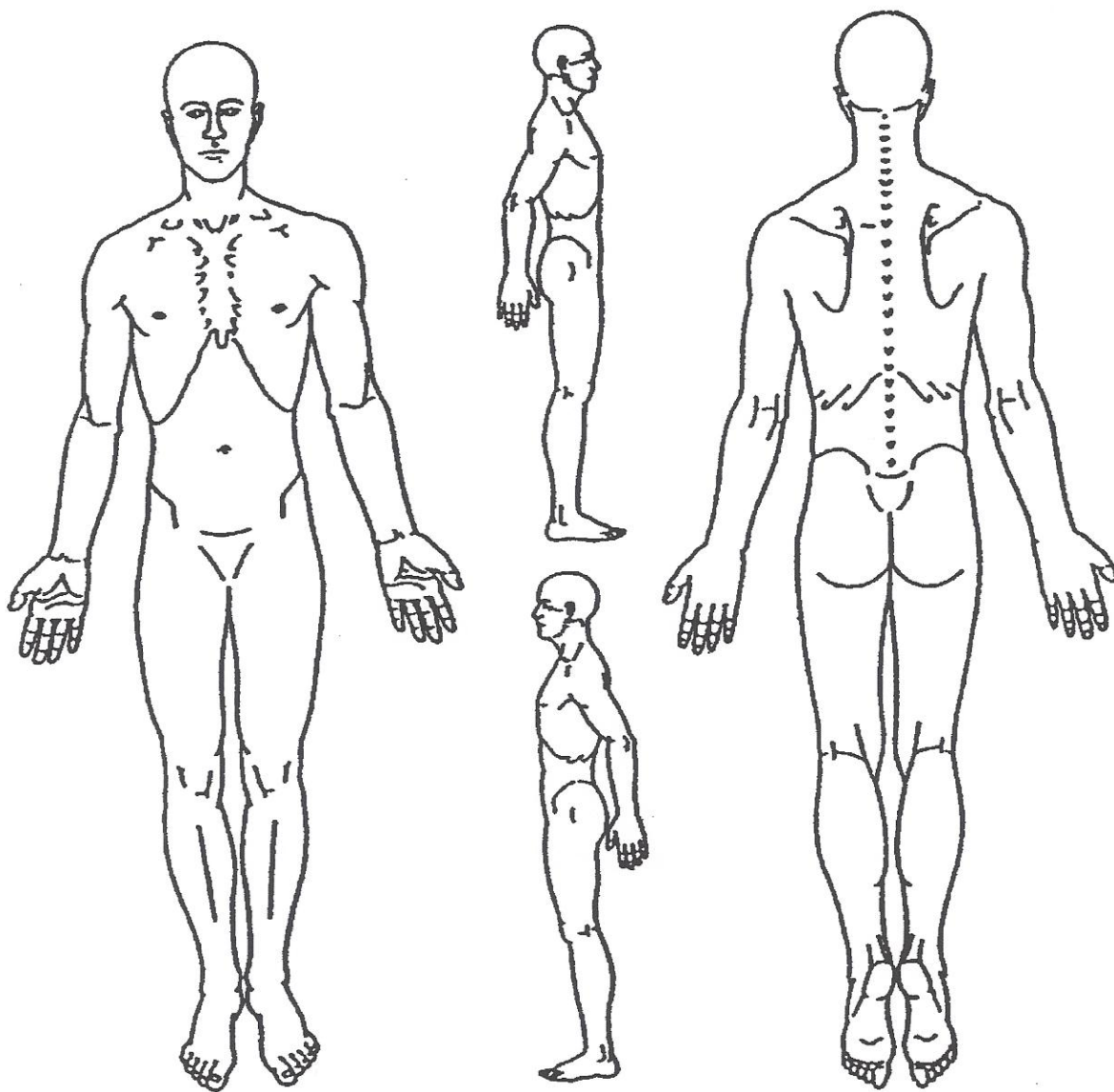
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYSTEMS 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 _____