

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

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

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 often |
| 7 <input type="checkbox"/> Cut heals slowly | 14 <input type="checkbox"/> "Nervous" stomach | |

GROUP TWO

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

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 hrs. | 106 <input type="checkbox"/> Stomach "bloating" after eating |

GROUP SEVEN

- | | | |
|--|--|--|
| <p>(A)</p> <p>107 <input type="checkbox"/> Insomnia</p> <p>108 <input type="checkbox"/> Nervousness</p> <p>109 <input type="checkbox"/> Can't gain weight</p> <p>110 <input type="checkbox"/> Intolerance to heat</p> <p>111 <input type="checkbox"/> Highly emotional</p> <p>112 <input type="checkbox"/> Flush easily</p> <p>113 <input type="checkbox"/> Night sweats</p> <p>114 <input type="checkbox"/> Thin, moist skin</p> <p>115 <input type="checkbox"/> Inward trembling</p> <p>116 <input type="checkbox"/> Heart palpitates</p> <p>117 <input type="checkbox"/> Increased appetite without weight gain</p> <p>118 <input type="checkbox"/> Pulse fast at rest</p> <p>119 <input type="checkbox"/> Eyelids and face twitch</p> <p>120 <input type="checkbox"/> Irritable and restless</p> <p>121 <input type="checkbox"/> Can't work under pressure</p> | <p>(C)</p> <p>137 <input type="checkbox"/> Failing memory</p> <p>138 <input type="checkbox"/> Low blood pressure</p> <p>139 <input type="checkbox"/> Increased sex drive</p> <p>140 <input type="checkbox"/> Headaches, "splitting or rending" type</p> <p>141 <input type="checkbox"/> Decreased sugar tolerance</p> | <p>(E)</p> <p>150 <input type="checkbox"/> Dizziness</p> <p>151 <input type="checkbox"/> Headaches</p> <p>152 <input type="checkbox"/> Hot flashes</p> <p>153 <input type="checkbox"/> Increased blood pressure</p> <p>154 <input type="checkbox"/> Hair growth on face or body (female)</p> <p>155 <input type="checkbox"/> Sugar in urine (not diabetes)</p> <p>156 <input type="checkbox"/> Masculine tendencies (female)</p> |
| <p>(B)</p> <p>122 <input type="checkbox"/> Increase in weight</p> <p>123 <input type="checkbox"/> Decrease in appetite</p> <p>124 <input type="checkbox"/> Fatigue easily</p> <p>125 <input type="checkbox"/> Ringing in ears</p> <p>126 <input type="checkbox"/> Sleepy during day</p> <p>127 <input type="checkbox"/> Sensitive to cold</p> <p>128 <input type="checkbox"/> Dry or scaly skin</p> <p>129 <input type="checkbox"/> Constipation</p> <p>130 <input type="checkbox"/> Mental sluggishness</p> <p>131 <input type="checkbox"/> Hair coarse, falls out</p> <p>132 <input type="checkbox"/> Headaches upon arising, wear off during day</p> <p>133 <input type="checkbox"/> Slow pulse, below 65</p> <p>134 <input type="checkbox"/> Frequency of urination</p> <p>135 <input type="checkbox"/> Impaired hearing</p> <p>136 <input type="checkbox"/> Reduced initiative</p> | <p>(D)</p> <p>142 <input type="checkbox"/> Abnormal thirst</p> <p>143 <input type="checkbox"/> Bloating of abdomen</p> <p>144 <input type="checkbox"/> Weight gain around hips or waist</p> <p>145 <input type="checkbox"/> Sex drive reduced or lacking</p> <p>146 <input type="checkbox"/> Tendency to ulcers, colitis</p> <p>147 <input type="checkbox"/> Increased sugar tolerance</p> <p>148 <input type="checkbox"/> Women: menstrual disorders</p> <p>149 <input type="checkbox"/> Young girls: lack of menstrual function</p> | <p>(F)</p> <p>157 <input type="checkbox"/> Weakness, dizziness</p> <p>158 <input type="checkbox"/> Chronic fatigue</p> <p>159 <input type="checkbox"/> Low blood pressure</p> <p>160 <input type="checkbox"/> Nails weak, ridged</p> <p>161 <input type="checkbox"/> Tendency to hives</p> <p>162 <input type="checkbox"/> Arthritic tendencies</p> <p>163 <input type="checkbox"/> Perspiration increase</p> <p>164 <input type="checkbox"/> Bowel disorders</p> <p>165 <input type="checkbox"/> Poor circulation</p> <p>166 <input type="checkbox"/> Swollen ankles</p> <p>167 <input type="checkbox"/> Crave salt</p> <p>168 <input type="checkbox"/> Brown spots or bronzing of skin</p> <p>169 <input type="checkbox"/> Allergies - tendency to asthma</p> <p>170 <input type="checkbox"/> Weakness after colds, influenza</p> <p>171 <input type="checkbox"/> Exhaustion - muscular and nervous</p> <p>172 <input type="checkbox"/> Respiratory disorders</p> |

SYMPTOM SURVEY FORM - PAGE 3

GROUP EIGHT

- 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 _____ |