

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 ○○○○ Acid foods upset | 8 ○○○○ Gag easily | 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

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| 21 ○○○○ Joint stiffness on arising | 29 ○○○○ Digestion rapid | 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

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| 42 ○○○○ Eat when nervous | 49 ○○○○ Heart palpitates if meals missed or delayed | 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

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|---|--|--|
| 56 ○○○○ Hands and feet go to sleep easily, numbness | 63 ○○○○ Get "drowsy" often | 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

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|---|--|--|
| <p>1 2 3
73 ○○○ Dizziness</p> <p>74 ○○○ Dry skin</p> <p>75 ○○○ Burning feet</p> <p>76 ○○○ Blurred vision</p> <p>77 ○○○ Itching skin and feet</p> <p>78 ○○○ Excessive falling hair</p> <p>79 ○○○ Frequent skin rashes</p> <p>80 ○○○ Bitter, metallic taste in mouth in mornings</p> <p>81 ○○○ Bowel movements painful or difficult</p> <p>82 ○○○ Worrier, feels insecure</p> | <p>1 2 3
83 ○○○ Feeling queasy; headache over eyes</p> <p>84 ○○○ Greasy foods upset</p> <p>85 ○○○ Stools light colored</p> <p>86 ○○○ Skin peels on foot soles</p> <p>87 ○○○ Pain between shoulder blades</p> <p>88 ○○○ Use laxatives</p> <p>89 ○○○ Stools alternate from soft to watery</p> <p>90 ○○○ History of gallbladder attacks or gallstones</p> | <p>1 2 3
91 ○○○ Sneezing attacks</p> <p>92 ○○○ Dreaming, nightmare type bad dreams</p> <p>93 ○○○ Bad breath (halitosis)</p> <p>94 ○○○ Milk products cause distress</p> <p>95 ○○○ Sensitive to hot weather</p> <p>96 ○○○ Burning or itching anus</p> <p>97 ○○○ Crave sweets</p> |
|---|--|--|

GROUP 6

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|--|---|--|
| <p>1 2 3
98 ○○○ Loss of taste for meat</p> <p>99 ○○○ Lower bowel gas several hours after eating</p> <p>100 ○○○ Burning stomach sensations, eating relieves</p> | <p>1 2 3
101 ○○○ Coated tongue</p> <p>102 ○○○ Pass large amounts of foul-smelling gas</p> <p>103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.</p> | <p>1 2 3
104 ○○○ Mucous colitis or "irritable bowel"</p> <p>105 ○○○ Gas shortly after eating</p> <p>106 ○○○ Stomach "bloating" after</p> |
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GROUP 7

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|---|--|--|
| <p>(A)</p> <p>1 2 3
107 ○○○ Insomnia</p> <p>108 ○○○ Nervousness</p> <p>109 ○○○ Can't gain weight</p> <p>110 ○○○ Intolerance to heat</p> <p>111 ○○○ Highly emotional</p> <p>112 ○○○ Flush easily</p> <p>113 ○○○ Night sweats</p> <p>114 ○○○ Thin, moist skin</p> <p>115 ○○○ Inward trembling</p> <p>116 ○○○ Heart palpitates</p> <p>117 ○○○ Increased appetite without weight gain</p> <p>118 ○○○ Pulse fast at rest</p> <p>119 ○○○ Eyelids and face twitch</p> <p>120 ○○○ Irritable and restless</p> <p>121 ○○○ Can't work under pressure</p> | <p>(C)</p> <p>1 2 3
137 ○○○ Failing memory</p> <p>138 ○○○ Low blood pressure</p> <p>139 ○○○ Increased sex drive</p> <p>140 ○○○ Headaches, "splitting or rending" type</p> <p>141 ○○○ Decreased sugar tolerance</p> | <p>(E)</p> <p>1 2 3
150 ○○○ Dizziness</p> <p>151 ○○○ Headaches</p> <p>152 ○○○ Hot flashes</p> <p>153 ○○○ Increased blood pressure</p> <p>154 ○○○ Hair growth on face or body (female)</p> <p>155 ○○○ Sugar in urine (not diabetes)</p> <p>156 ○○○ Masculine tendencies (female)</p> |
| <p>(B)</p> <p>1 2 3
122 ○○○ Increase in weight</p> <p>123 ○○○ Decrease in appetite</p> <p>124 ○○○ Fatigue easily</p> <p>125 ○○○ Ringing in ears</p> <p>126 ○○○ Sleepy during day</p> <p>127 ○○○ Sensitive to cold</p> <p>128 ○○○ Dry or scaly skin</p> <p>129 ○○○ Constipation</p> <p>130 ○○○ Mental sluggishness</p> <p>131 ○○○ Hair coarse, falls out</p> <p>132 ○○○ Headaches upon arising, wear off during day</p> <p>133 ○○○ Slow pulse, below 65</p> <p>134 ○○○ Frequency of urination</p> <p>135 ○○○ Impaired hearing</p> <p>136 ○○○ Reduced initiative</p> | <p>(D)</p> <p>1 2 3
142 ○○○ Abnormal thirst</p> <p>143 ○○○ Bloating of abdomen</p> <p>144 ○○○ Weight gain around hips or waist</p> <p>145 ○○○ Sex drive reduced or lacking</p> <p>146 ○○○ Tendency to ulcers, colitis</p> <p>147 ○○○ Increased sugar tolerance</p> <p>148 ○○○ Women: menstrual disorders</p> <p>149 ○○○ Young girls: lack of menstrual function</p> | <p>(F)</p> <p>1 2 3
157 ○○○ Weakness, dizziness</p> <p>158 ○○○ Chronic fatigue</p> <p>159 ○○○ Low blood pressure</p> <p>160 ○○○ Nails weak, ridged</p> <p>161 ○○○ Tendency to hives</p> <p>162 ○○○ Arthritic tendencies</p> <p>163 ○○○ Perspiration increase</p> <p>164 ○○○ Bowel disorders</p> <p>165 ○○○ Poor circulation</p> <p>166 ○○○ Swollen ankles</p> <p>167 ○○○ Crave salt</p> <p>168 ○○○ Brown spots or bronzing of skin</p> <p>169 ○○○ Allergies - tendency to asthma</p> <p>170 ○○○ Weakness after colds, influenza</p> <p>171 ○○○ Exhaustion - muscular and nervous</p> <p>172 ○○○ Respiratory disorders</p> |

SYSTEMS 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 _____

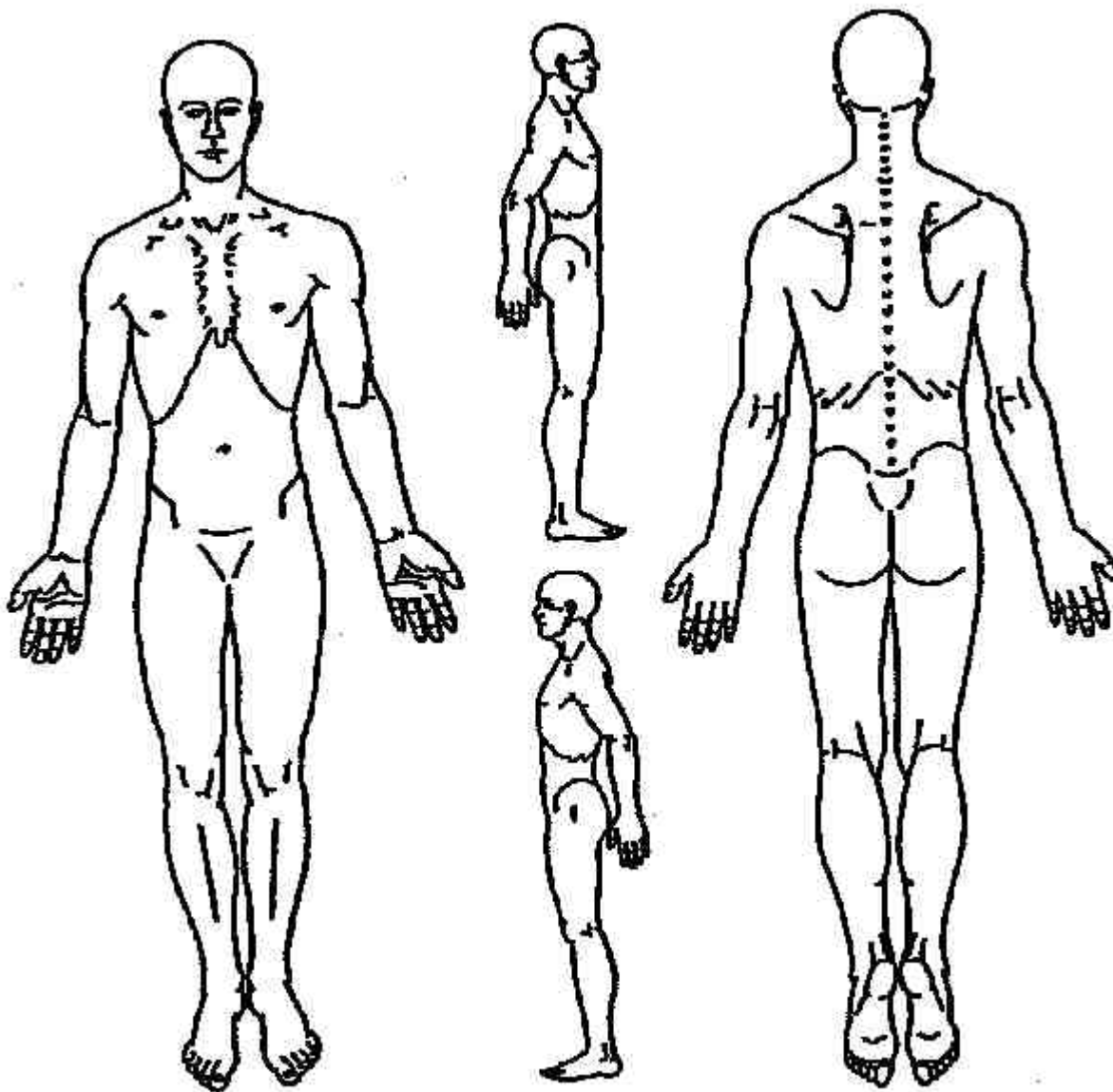
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

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 _____