

# SYMPTOM SURVEY FORM

(Restricted to Professional Use)

DATE \_\_\_\_\_

PATIENT \_\_\_\_\_ DOCTOR \_\_\_\_\_ DOB \_\_\_\_\_

**INSTRUCTIONS: NUMBER** the boxes which apply to you. Use (1) if the symptom occurs once or twice a year, (2) if it occurs several times per month, and (3) if you are aware of it constantly.

<b>GROUP ONE</b>		
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"	
<b>GROUP TWO</b>		
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 seems hungry; feels "lightheaded" often	36 <input type="checkbox"/> Constipation, diarrhea alternating	
<b>GROUP THREE</b>		
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		
<b>GROUP FOUR</b>		
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"		

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- 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

**GROUP FIVE**

- 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 SIX**

- 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 ½ - 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

**(A)**

**GROUP SEVEN**

- 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 wt. gain
- 118  Pulse fast at rest
- 119  Eyelids and face twitch
- 120  Irritable and restless
- 121  Can't work under pressure
- 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

FEMALE ONLY	GROUP EIGHT
<p>173 <input type="checkbox"/> Very easily fatigued</p> <p>174 <input type="checkbox"/> Premenstrual tension</p> <p>175 <input type="checkbox"/> Painful menses</p> <p>176 <input type="checkbox"/> Depressed feelings before menstruation</p> <p>177 <input type="checkbox"/> Menstruation excessive</p> <p>178 <input type="checkbox"/> Painful breasts</p> <p>179 <input type="checkbox"/> Menstruate too frequently</p> <p>180 <input type="checkbox"/> Vaginal discharge</p>	<p>198 <input type="checkbox"/> Apprehension</p> <p>199 <input type="checkbox"/> Irritability</p> <p>200 <input type="checkbox"/> Morbid fears</p> <p>201 <input type="checkbox"/> Hypochondria</p> <p>202 <input type="checkbox"/> Forgetfulness</p> <p>203 <input type="checkbox"/> Indigestion</p> <p>204 <input type="checkbox"/> Poor Appetite</p> <p>205 <input type="checkbox"/> Craving for sweets</p> <p>206 <input type="checkbox"/> Muscular soreness</p> <p>207 <input type="checkbox"/> Depression</p> <p>208 <input type="checkbox"/> Noise sensitivity</p> <p>209 <input type="checkbox"/> Acoustic hallucinations</p> <p>210 <input type="checkbox"/> Tendency to cry without reason</p> <p>211 <input type="checkbox"/> Feeling something dreadful will happen</p> <p>212 <input type="checkbox"/> Weakness</p> <p>213 <input type="checkbox"/> Fatigue</p> <p>214 <input type="checkbox"/> Neuralgia</p> <p>215 <input type="checkbox"/> Neuritis</p>
<p>181 <input type="checkbox"/> Hysterectomy/ovaries removed</p> <p>182 <input type="checkbox"/> Menopausal hot flashes</p> <p>183 <input type="checkbox"/> Menses scanty or missed</p> <p>184 <input type="checkbox"/> Acne, worse at menses</p> <p>185 <input type="checkbox"/> Depression of long standing</p>	<p>216 <input type="checkbox"/> Nervousness</p> <p>217 <input type="checkbox"/> Headache</p> <p>218 <input type="checkbox"/> Insomnia</p> <p>219 <input type="checkbox"/> Anxiety</p> <p>220 <input type="checkbox"/> Anorexia</p> <p>221 <input type="checkbox"/> Distraction</p> <p>222 <input type="checkbox"/> Confusion</p> <p>223 <input type="checkbox"/> Dizziness</p> <p>224 <input type="checkbox"/> Instability</p>
<p><b>MALE ONLY</b></p> <p>186 <input type="checkbox"/> Prostate trouble</p> <p>187 <input type="checkbox"/> Urination difficult or dribbling</p> <p>188 <input type="checkbox"/> Night urination frequent</p> <p>189 <input type="checkbox"/> Depression</p> <p>190 <input type="checkbox"/> Pain on inside of legs or heels</p> <p>191 <input type="checkbox"/> Feeling of incomplete bowel evacuation</p> <p>192 <input type="checkbox"/> Lack of energy</p> <p>193 <input type="checkbox"/> Migrating aches and pains</p> <p>194 <input type="checkbox"/> Tire too easily</p> <p>195 <input type="checkbox"/> Avoids activity</p> <p>196 <input type="checkbox"/> Leg nervousness at night</p> <p>197 <input type="checkbox"/> Diminished sex drive</p>	<p style="text-align: center;"><b>IMPORTANT</b></p> <p>TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>