

# SYMPTOM SURVEY FORM

Patient \_\_\_\_\_ Doctor \_\_\_\_\_ Date \_\_\_\_\_

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 (occur once or twice a year).

\* Write 2 in the box for MODERATE symptoms (occur several times a month).

\* Write 3 in the box for SEVERE symptoms (you are aware of it almost constantly).

**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

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

### GROUP SIX

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

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

# SYMPTOM SURVEY FORM - PAGE 3

## GROUP EIGHT

- 198  Apprehension
- 199  Irritability
- 200  Morbid fears
- 201  Never seems to get well
- 202  Forgetfulness
- 203  Indigestion
- 204  Poor appetite
- 205  Craving for sweets
- 206  Muscular soreness
- 207  Depression; feelings of dread

- 208  Noise sensitivity
- 209  Accoustic hallucinations
- 210  Tendency to cry without reason
- 211  Hair is coarse and/or thinning
- 212  Weakness
- 213  Fatigue
- 214  Skin sensitive to touch
- 215  Tendency toward hives
- 216  Nervousness
- 217  Headache

- 218  Insomnia
- 219  Anxiety
- 220  Anorexia
- 221  Inability to concentrate; confusion
- 222  Frequent stuffy nose; sinus infections
- 223  Allergy to some foods
- 224  Loose joints

### FEMALE ONLY

- 173  Very easily fatigued
- 174  Premenstrual tension
- 175  Painful menses
- 176  Depressed feelings before menstruation
- 177  Menstruation excessive and prolonged
- 178  Painful breasts

- 179  Menstruate too frequently
- 180  Vaginal discharge
- 181  Hysterectomy/overies removed
- 182  Menopausal hot flashes
- 183  Menses scanty or missed
- 184  Acne, worse at menses
- 185  Depression of long standing

### MALE ONLY

- 186  Prostate trouble
- 187  Urination difficult or dribbling
- 188  Night urination frequent
- 189  Depression
- 190  Pain on inside of legs or heels
- 191  Feeling of incomplete bowel evacuation
- 192  Lack of energy
- 193  Migrating aches and pains
- 194  Tire too easily
- 195  Avoids activity
- 196  Leg nervousness at night
- 197  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 MENSTRAUL 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 _____ |