

# SYSTEMS SURVEY FORM

Patient	Doctor	Date						
Birth Date/ Approx Weight Vegetarian: Yes  No								
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 0 0 Acid foods upset 2 0 0 Get chilled often 3 0 0 "Lump" in throat 4 0 0 Dry mouth-eyes-nose 5 0 0 Pulse speeds after meal 6 0 0 Keyed up - fail to calm 7 0 0 Cut heals slowly	1 2 3 8 0 0 Gag easily 9 0 0 Unable to relax; startles easily 10 0 0 Extremities cold, clammy 11 0 0 Strong light irritates 12 0 0 Urine amount reduced 13 0 0 Heart pounds after retiring 14 0 0 "Nervous" stomach	1 2 3 15 ○ ○ Appetite reduced 16 ○ ○ Cold sweats often 17 ○ ○ Fever easily raised 18 ○ ○ Neuralgia-like pains 19 ○ ○ Staring, blinks little 20 ○ ○ Sour stomach often						
	GROUP 2							
1 2 3 21 0 0 Joint stiffness on arising 22 0 0 Muscle-leg-toe cramps at night 23 0 0 "Butterfly" stomach, cramps 24 0 0 Eyes or nose watery 25 0 0 Eyes blink often 26 0 0 Eyelids swollen, puffy 27 0 0 Indigestion soon after meals 28 0 0 Always seems hungry; feels "lightheaded" often	1 2 3 29 O O Digestion rapid 30 O O Vomiting frequent 31 O O Hoarseness frequent 32 O O Breathing irregular 33 O O Pulse slow; feels "irregular" 34 O O Gagging reflex slow 35 O O Difficulty swallowing 36 O O Constipation, diarrhea alternating	1 2 3 37 000 "Slow starter" 38 000 Get "chilled" infrequently 39 000 Perspire easily 40 000 Circulation poor, sensitive to cold 41 000 Subject to colds, asthma, bronchitis						
	GROUP 3							
1 2 3 42 0 0 Eat when nervous 43 0 0 Excessive appetite 44 0 0 Hungry between meals 45 0 0 Irritable before meals 46 0 0 Get "shaky" if hungry 47 0 0 Fatigue, eating relieves 48 0 0 "Lightheaded" if meals delayed	1 2 3 49	1 2 3 53 OOO Crave candy or coffee in afternoons 54 OOO Moods of depression - "blues" or melancholy 55 OOO Abnormal craving for sweets or snacks						
GROUP 4 1 2 3 1 2 3								
1 2 3 56 000 Hands and feet go to sleep easily, numbness 57 000 Sigh frequently, "air hunger" 58 000 Aware of "breathing heavily" 59 000 High altitude discomfort 60 000 Opens windows in closed rooms 61 000 Susceptible to colds and fevers 62 000 Afternoon "yawner"	63 O O Get "drowsy" often 64 O O Swollen ankles, worse at night 65 O O Muscle cramps, worse during exercise; get "charley horses" 66 O O Shortness of breath on exertion 67 O O Dull pain in chest or radiating into left arm, worse on exertion	68 OOO Bruise easily, "black and blue" spots 69 OOO Tendency to anemia 70 OOO "Nose bleeds" frequent 71 OOO Noises in head, or "ringing in ears" 72 OOO Tension under the breastbone, or feeling of "tightness", worse on exertion						

GROUP 5					
1 2 3	1 2 3	1 2 3			
73 OOO Dizziness	83 OOO Feeling queasy; headache over	91 OOO Sneezing attacks			
74 000 Dry skin	eyes	92 OOO Dreaming, nightmare type bad			
75 OOO Burning feet	84 O O Greasy foods upset	dreams			
76 OOO Blurred vision	85 O O O Stools light colored	93 OOO Bad breath (halitosis)			
77 OOO Itching skin and feet	86 OOO Skin peels on foot soles	94 OOO Milk products cause distress			
78 OOO Excessive falling hair	87 O O Pain between shoulder blades	95 OOO Sensitive to hot weather			
79 OOO Frequent skin rashes	88 OOO Use laxatives	96 OOO Burning or itching anus			
80 OOO Bitter, metallic taste in mouth in mornings	89 OOO Stools alternate from soft to watery	97 OOO Crave sweets			
81 OOO Bowel movements painful or difficult	90 O O History of gallbladder attacks or gallstones				
82 OOO Worrier, feels insecure	GROUP 6				
7.2.2	1 2 3	1 2 3			
1 2 3 98 OOO Loss of taste for meat	101 OOO Coated tongue	104 OOO Mucous colitis or "irritable			
99 OOO Lower bowel gas several hour		bowel"			
after eating	foul-smelling gas	105 O O O Gas shortly after eating			
100 OOO Burning stomach sensations, eating relieves	103 O O Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.	106 O O O Stomach "bloating" after			
eaulig relieves	GROUP 7				
	GROOF /	9200			
1 2 3 (A)		1 2 3 (E)			
107 OOO Insomnia		150 O O Dizziness			
108 OOO Nervousness	4001.5	151 OOO Headaches			
109 OOO Can't gain weight	1 2 3 (C)	152 OOO Hot flashes			
110 OOO Intolerance to heat	137 OOO Failing memory	153 OOO Increased blood pressure			
111 OOO Highly emotional	138 OOO Low blood pressure				
112 OOO Flush easily	139 OOO Increased sex drive	154 OOO Hair growth on face or body			
113 OOO Night sweats	140 OOO Headaches, "splitting or	(female)			
114 OOO Thin, moist skin	rending" type	155 O O O Sugar in urine			
115 OOO Inward trembling	141 OOO Decreased sugar tolerance	(not diabetes)			
116 OOO Heart palpitates		156 O O O Masculine tendencies			
117 OOO Increased appetite without		(female)			
weight gain					
118 OOO Pulse fast at rest	1 2 3 (D)	2 no feet			
119 OOO Eyelids and face twitch	142 OOO Abnormal thirst	1 2 3 (F)			
120 OOO Irritable and restless	143 OOO Bloating of abdomen	157 OOO Weakness, dizziness			
121 OOO Can't work under pressure	144 OOO Weight gain around hips or	158 OOO Chronic fatigue			
	waist	159 OOO Low blood pressure			
1 2 3 (B)	145 OOO Sex drive reduced or lacking	160 OOO Nails weak, ridged			
122 000 Increase in weight	146 OOO Tendency to ulcers, colitis	161 OOO Tendency to hives			
123 OOO Decrease in appetite	147 OOO Increased sugar tolerance	162 OOO Arthritic tendencies			
	148 OOO Women; menstrual disorders	163 OOO Perspiration increase			
124 O O Fatigue easily	149 OOO Young girls: lack of menstrual	164 OOO Bowel disorders			
125 OOO Ringing in ears 126 OOO Sleepy during day	function	165 OOO Poor circulation			
		166 OOO Swollen ankles			
127 O O Sensitive to cold		167 OOO Crave salt			
128 OOO Dry or scaly skin		168 OOO Brown spots or bronzing of			
129 O O Constipation 130 O O Mental sluggishness		skin			
131 OOO Hair coarse, falls out		169 OOO Allergies - tendency to			
132 OOO Headaches upon arising, we	ar	asthma			
off during day	sat ,	170 OOO Weakness after colds, influenza			
133 OOO Slow pulse, below 65 134 OOO Frequency of urination		171 OOO Exhaustion - muscular and nervous			
135 OOO Impaired hearing		172 OOO Respiratory disorders			

GROUP 8								
1 2 3 173 O O Apprehension 174 O O Irritability 175 O O Morbid fears 176 O O Never seems to get well 177 O O Forgetfulness 178 O O Indigestion 179 O O Poor appetite 180 O O Craving for sweets 181 O O Muscular soreness 182 O O Depression; feelings of dread	1 2 3  183 O Noise sensitivity  184 O Acoustic hallucinations  185 O Hair is coarse and/or thinning  187 O Weakness  188 O Fatigue  189 O Skin sensitive to touch  190 O Tendency toward hives  191 O Nervousness  192 O Headache	1 2 3 193 O O Insomnia 194 O O Anxiety 195 O O Anorexia 196 O O Inability to concentrate; confusion 197 O O Frequent stuffy nose; sinus infections 198 O O Allergy to some foods 199 O O Loose joints						
FEMAL	E ONLY-	MALE ONLY						
PEMALE ONLY  1 2 3 200 ○ ○ Very easily fatigued 206 ○ ○ Menstruate too frequently 201 ○ ○ Premenstrual tension 207 ○ ○ Vaginal discharge 202 ○ ○ Painful menses 208 ○ Hysterectomy / ovaries removed 203 ○ ○ Depressed feelings before menstruation 209 ○ ○ Menopausal hot flashes 204 ○ ○ Menstruation excessive and prolonged 211 ○ ○ Acne, worse at menses 205 ○ ○ Painful breasts 212 ○ ○ Depression of long standing  IMPORTANT  Please list the five main complaints you have in the order of their importance:  1		213 O O Prostate trouble 214 O O Urination difficult or dribbling 215 O O Night urination frequent 216 O O Depression 217 O O Pain on inside of legs or heels  218 O O Feeling of incomplete bowel evacuation  219 O O Lack of energy 220 O O Migrating aches and pains 221 O O Tire too easily 222 O O Avoids activity 223 O O Leg nervousness at night 224 O O Diminished sex drive						
2		-						
4	EST  . and is a measurement of yperthyroid states. The test ag bed - with the sinvalidated if the patient g up for any reason, shaking test be conducted for	Temperature						

Date

Date

Date

Temperature

Temperature

Temperature

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

Please list any medications you are taking:	☐ No Medications						
Please list any vitamins, herbs, or supplements you are t	aking:			☐ No Vitamins			
Disease list are allowing your bound				☐ No Allergies			
Please list any allergies you have:				I No Alloigies			
Please list any surgeries you have had in the past 12 mo	nths:			□ 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							
Occult Blood pH of Saliva		pH of Stool Specimen					
Blood Clotting Time — Hemoglobin —		Blood Type		Weight			

Use the letters listed below to indicate the type and location of your pain and sensations:

#### KEY

A = ACHE

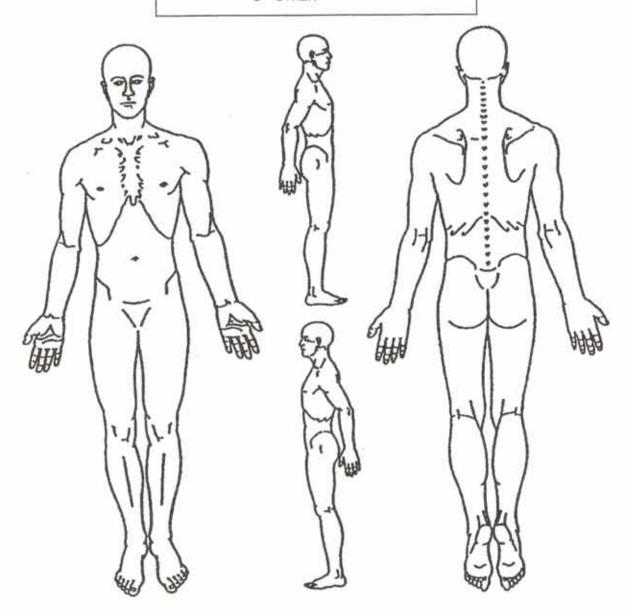
B = BURNING

S = STABBING

N = NUMBNESS

P = PINS & NEEDLES

O = OTHER



#### PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

SEVERE PAIN NO PAIN 10

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