

SYMPTOM SURVEY FORM
(Restricted to Professional Use)

LEAVE BLANK IF
SYMPTOM DOES NOT APPLY

PATIENT _____ DOCTOR _____ DATE _____

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice a year), (2) for MODERATE symptoms (occur several times a year), and (3) for SEVERE symptoms (you are aware of it almost constantly).

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 frequent |
| 7 <input type="checkbox"/> Cuts heal slowly | 14 <input type="checkbox"/> "Nervous" stomach | |

GROUP TWO

- | | | |
|--|--|--|
| 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 | |

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 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" | | |

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

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

FEMALE ONLY

- | | |
|---|---|
| 173 <input type="checkbox"/> Very easily fatigued | 181 <input type="checkbox"/> Hysterectomy/ovaries removed |
| 174 <input type="checkbox"/> Premenstrual tension | 182 <input type="checkbox"/> Menopausal hot flashes |
| 175 <input type="checkbox"/> Painful menses | 183 <input type="checkbox"/> Menses scanty or missed |
| 176 <input type="checkbox"/> Depressed feelings before menstruation | 184 <input type="checkbox"/> Acne, worse at menses |
| 177 <input type="checkbox"/> Menstruation excessive and prolonged | 185 <input type="checkbox"/> Depression of long standing |
| 178 <input type="checkbox"/> Painful breasts | |
| 179 <input type="checkbox"/> Menstruate too frequently | |
| 180 <input type="checkbox"/> Vaginal discharge | |

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

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____