

# SYMPTOM SURVEY FORM



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

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Approx Weight \_\_\_\_\_ 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 (occurred once or twice last 6 months).

\* Write 2 in the box for MODERATE symptoms (occurred once or twice last month).

\* Write 3 in the box for SEVERE symptoms (chronic, occurred once or twice last week).

**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

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|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| 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 |
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### 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 |

