

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____

Birth Date ____ / ____ / ____ Approx Weight _____ Vegetarian ☐ Gluten-free ☐

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 (occurs rarely).

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

* Write 3 in the box for SEVERE symptoms (occurs almost constantly).

Please do not use checkmarks in the boxes - fill in the boxes with a number or leave blank!

GROUP 1

- | | | |
|--|---|--|
| 1 <input type="checkbox"/> Acid foods upset | 8 <input type="checkbox"/> Unable to relax; startles easily | 15 <input type="checkbox"/> Cold sweats often |
| 2 <input type="checkbox"/> Get chilled often | 9 <input type="checkbox"/> Extremities cold, clammy | 16 <input type="checkbox"/> Get heated easily |
| 3 <input type="checkbox"/> "Lump" in throat | 10 <input type="checkbox"/> Strong light irritates | 17 <input type="checkbox"/> Nerve discomfort |
| 4 <input type="checkbox"/> Dry mouth-eyes-nose | 11 <input type="checkbox"/> Occasionally weak urine flow | 18 <input type="checkbox"/> Staring, blinks little |
| 5 <input type="checkbox"/> Pulse speeds after meal | 12 <input type="checkbox"/> Heart pounds after retiring | 19 <input type="checkbox"/> Sour stomach frequent |
| 6 <input type="checkbox"/> Keyed up - fail to calm | 13 <input type="checkbox"/> "Nervous" stomach | |
| 7 <input type="checkbox"/> Gag occasionally | 14 <input type="checkbox"/> Appetite reduced occasionally | |

GROUP 2

- | | | |
|--|--|--|
| 20 <input type="checkbox"/> Joint stiffness on arising | 28 <input type="checkbox"/> Digestion rapid | 36 <input type="checkbox"/> "Slow starter" |
| 21 <input type="checkbox"/> Muscle-leg-toe cramps at night | 29 <input type="checkbox"/> Vomiting occasionally | 37 <input type="checkbox"/> Get "chilled" |
| 22 <input type="checkbox"/> "Butterfly" stomach, cramps | 30 <input type="checkbox"/> Hoarseness frequent | 38 <input type="checkbox"/> Perspire easily |
| 23 <input type="checkbox"/> Eyes or nose watery | 31 <input type="checkbox"/> Uneven breathing | 39 <input type="checkbox"/> Sensitive to cold |
| 24 <input type="checkbox"/> Eyes blink often | 32 <input type="checkbox"/> Pulse slow | 40 <input type="checkbox"/> Upper respiratory challenges |
| 25 <input type="checkbox"/> Eyelids swollen, puffy | 33 <input type="checkbox"/> Gagging reflex slow | |
| 26 <input type="checkbox"/> Indigestion soon after meals | 34 <input type="checkbox"/> Difficulty swallowing | |
| 27 <input type="checkbox"/> Always seems hungry; feels "lightheaded" often | 35 <input type="checkbox"/> Temporary constipation or diarrhea | |

GROUP 3

- | | | |
|--|--|---|
| 41 <input type="checkbox"/> Eat when nervous | 48 <input type="checkbox"/> Heart palpitates if meals missed or delayed | 52 <input type="checkbox"/> Crave candy or coffee in afternoons |
| 42 <input type="checkbox"/> Excessive appetite | 49 <input type="checkbox"/> Fatigue in afternoons | 53 <input type="checkbox"/> Moods of "blues" or melancholy |
| 43 <input type="checkbox"/> Hungry between meals | 50 <input type="checkbox"/> Overeating sweets upsets | 54 <input type="checkbox"/> Craving for sweets or snacks |
| 44 <input type="checkbox"/> Irritable before meals | 51 <input type="checkbox"/> Awaken after few hours sleep - hard to get back to sleep | |
| 45 <input type="checkbox"/> Get "shaky" if hungry | | |
| 46 <input type="checkbox"/> Fatigue, eating relieves | | |
| 47 <input type="checkbox"/> "Lightheaded" if meals delayed | | |

GROUP 4

- | | | |
|---|--|--|
| 55 <input type="checkbox"/> Hands and feet go to sleep easily, numbness | 62 <input type="checkbox"/> Get "drowsy" often | 67 <input type="checkbox"/> Skin discolors easily after impact |
| 56 <input type="checkbox"/> Sigh frequently, "air hunger" | 63 <input type="checkbox"/> Swollen ankles, worse at night | 68 <input type="checkbox"/> Tendency to anemia |
| 57 <input type="checkbox"/> Aware of "breathing heavily" | 64 <input type="checkbox"/> Muscle cramps, worse during exercise; get "charley horses" | 69 <input type="checkbox"/> Noises in head, or "ringing in ears" |
| 58 <input type="checkbox"/> High altitude discomfort | 65 <input type="checkbox"/> Difficulty catching breath, especially during exercise | 70 <input type="checkbox"/> Fatigue upon exertion |
| 59 <input type="checkbox"/> Opens windows in closed rooms | 66 <input type="checkbox"/> Tightness or pressure in chest, worse on exertion | |
| 60 <input type="checkbox"/> Immune system challenges | | |
| 61 <input type="checkbox"/> Afternoon "yawner" | | |

GROUP 5

- | | | |
|---|--|---|
| 71 <input type="checkbox"/> Dizziness | 81 <input type="checkbox"/> Nausea occasionally after eating | 88 <input type="checkbox"/> Sneezing attacks |
| 72 <input type="checkbox"/> Dry skin | 82 <input type="checkbox"/> Greasy foods upset | 89 <input type="checkbox"/> Dreaming, nightmare type bad dreams |
| 73 <input type="checkbox"/> Burning feet | 83 <input type="checkbox"/> Stools light colored | 90 <input type="checkbox"/> Bad breath (halitosis) |
| 74 <input type="checkbox"/> Blurred vision | 84 <input type="checkbox"/> Skin peels on foot soles | 91 <input type="checkbox"/> Milk products cause upset |
| 75 <input type="checkbox"/> Itching skin and feet | 85 <input type="checkbox"/> Discomfort between shoulder blades | 92 <input type="checkbox"/> Sensitive to hot weather |
| 76 <input type="checkbox"/> Hair loss | 86 <input type="checkbox"/> Occasional laxative use | 93 <input type="checkbox"/> Burning or itching anus |
| 77 <input type="checkbox"/> Occasional skin rashes | 87 <input type="checkbox"/> Stools alternate from soft to watery | 94 <input type="checkbox"/> Crave sweets |
| 78 <input type="checkbox"/> Bitter, metallic taste in mouth in mornings | | |
| 79 <input type="checkbox"/> Occasional constipation | | |
| 80 <input type="checkbox"/> Worrier, feels insecure | | |

GROUP 6

- | | | |
|---|---|---|
| 95 <input type="checkbox"/> Loss of taste for meat | 98 <input type="checkbox"/> Coated tongue | 101 <input type="checkbox"/> Watery or loose stool |
| 96 <input type="checkbox"/> Lower bowel gas several hours after eating | 99 <input type="checkbox"/> Pass large amounts of foul-smelling gas | 102 <input type="checkbox"/> Gas shortly after eating |
| 97 <input type="checkbox"/> Burning stomach sensations, eating relieves | 100 <input type="checkbox"/> Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs. | 103 <input type="checkbox"/> Stomach "bloating" |

GROUP 7

- | | | |
|--|---|--|
| <p>(A)</p> <p>104 <input type="checkbox"/> Difficulty sleeping</p> <p>105 <input type="checkbox"/> On edge</p> <p>106 <input type="checkbox"/> Can't gain weight</p> <p>107 <input type="checkbox"/> Intolerance to heat</p> <p>108 <input type="checkbox"/> Highly emotional</p> <p>109 <input type="checkbox"/> Flush easily</p> <p>110 <input type="checkbox"/> Night sweats</p> <p>111 <input type="checkbox"/> Thin, moist skin</p> <p>112 <input type="checkbox"/> Inward trembling</p> <p>113 <input type="checkbox"/> Heart races</p> <p>114 <input type="checkbox"/> Increased appetite without weight gain</p> <p>115 <input type="checkbox"/> Pulse fast at rest</p> <p>116 <input type="checkbox"/> Eyelids and face twitch</p> <p>117 <input type="checkbox"/> Irritable and restless</p> <p>118 <input type="checkbox"/> Can't work under pressure</p> | <p>(C)</p> <p>134 <input type="checkbox"/> Failing memory with age</p> <p>135 <input type="checkbox"/> Increased sex drive</p> <p>136 <input type="checkbox"/> Episodes of tension in head</p> <p>137 <input type="checkbox"/> Decreased sugar tolerance</p> | <p>(E)</p> <p>145 <input type="checkbox"/> Dizziness</p> <p>146 <input type="checkbox"/> Headaches</p> <p>147 <input type="checkbox"/> Hot flashes</p> <p>148 <input type="checkbox"/> Hair growth on face or body (female)</p> <p>149 <input type="checkbox"/> Sugar in urine (not diabetes)</p> <p>150 <input type="checkbox"/> Masculine tendencies (female)</p> |
| <p>(B)</p> <p>119 <input type="checkbox"/> Increase in weight</p> <p>120 <input type="checkbox"/> Decrease in appetite</p> <p>121 <input type="checkbox"/> Fatigue easily</p> <p>122 <input type="checkbox"/> Ringing in ears</p> <p>123 <input type="checkbox"/> Sleepy during day</p> <p>124 <input type="checkbox"/> Sensitive to cold</p> <p>125 <input type="checkbox"/> Dry or scaly skin</p> <p>126 <input type="checkbox"/> Temporary constipation</p> <p>127 <input type="checkbox"/> Mental sluggishness</p> <p>128 <input type="checkbox"/> Hair coarse, falls out</p> <p>129 <input type="checkbox"/> Tension in head upon arising, wears off during day</p> <p>130 <input type="checkbox"/> Slow pulse, below 65</p> <p>131 <input type="checkbox"/> Changing urinary function</p> <p>132 <input type="checkbox"/> Sounds appear diminished</p> <p>133 <input type="checkbox"/> Reduced initiative</p> | <p>(D)</p> <p>138 <input type="checkbox"/> Abnormal thirst</p> <p>139 <input type="checkbox"/> Bloating of abdomen</p> <p>140 <input type="checkbox"/> Weight gain around hips or waist</p> <p>141 <input type="checkbox"/> Sex drive reduced or lacking</p> <p>142 <input type="checkbox"/> Tendency for stomach issues</p> <p>143 <input type="checkbox"/> Increased sugar tolerance</p> <p>144 <input type="checkbox"/> Menstrual disorders</p> | <p>(F)</p> <p>151 <input type="checkbox"/> Weakness, dizziness</p> <p>152 <input type="checkbox"/> Tired throughout day</p> <p>153 <input type="checkbox"/> Nails weak, ridged</p> <p>154 <input type="checkbox"/> Sensitive skin</p> <p>155 <input type="checkbox"/> Stiff joints</p> <p>156 <input type="checkbox"/> Perspiration increase</p> <p>157 <input type="checkbox"/> Bowel discomfort</p> <p>158 <input type="checkbox"/> Poor circulation</p> <p>159 <input type="checkbox"/> Swollen ankles</p> <p>160 <input type="checkbox"/> Crave salt</p> <p>161 <input type="checkbox"/> Areas of skin darkening</p> <p>162 <input type="checkbox"/> Upper respiratory sensitivity</p> <p>163 <input type="checkbox"/> Tiredness</p> <p>164 <input type="checkbox"/> Breathing challenges</p> |

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8

- | | | |
|---|---|--|
| 165 <input type="checkbox"/> Muscle weakness | 175 <input type="checkbox"/> Tendency to consume sweets or carbohydrates | 184 <input type="checkbox"/> Visible veins on chest and abdomen |
| 166 <input type="checkbox"/> Lack of Stamina | 176 <input type="checkbox"/> Muscle spasms | 185 <input type="checkbox"/> Hemorrhoids |
| 167 <input type="checkbox"/> Drowsiness after eating | 177 <input type="checkbox"/> Blurred vision | 186 <input type="checkbox"/> Apprehension (feeling that something bad will happen) |
| 168 <input type="checkbox"/> Muscular soreness | 178 <input type="checkbox"/> Involuntary muscle action | 187 <input type="checkbox"/> Nervousness causing loss of appetite |
| 169 <input type="checkbox"/> Heart races | 179 <input type="checkbox"/> Numbness | 188 <input type="checkbox"/> Nervousness with indigestion |
| 170 <input type="checkbox"/> Hyper-irritable | 180 <input type="checkbox"/> Night sweats | 189 <input type="checkbox"/> Gastritis |
| 171 <input type="checkbox"/> Feeling of a band around your head | 181 <input type="checkbox"/> Rapid digestion | 190 <input type="checkbox"/> Forgetfulness |
| 172 <input type="checkbox"/> Melancholia (feeling of sadness) | 182 <input type="checkbox"/> Sensitivity to noise | 191 <input type="checkbox"/> Thinning hair |
| 173 <input type="checkbox"/> Swelling of ankles | 183 <input type="checkbox"/> Redness of palms of hands and bottom of feet | |
| 174 <input type="checkbox"/> Change in urinary function | | |

FEMALE ONLY

- | | |
|---|--|
| 192 <input type="checkbox"/> Very easily fatigued | 197 <input type="checkbox"/> Menstruate too frequently |
| 193 <input type="checkbox"/> Premenstrual tension | 198 <input type="checkbox"/> Hysterectomy/ovaries removed (write number 3) |
| 194 <input type="checkbox"/> Menses more painful than usual | 199 <input type="checkbox"/> Menopausal hot flashes |
| 195 <input type="checkbox"/> Depressed feelings before menstruation | 200 <input type="checkbox"/> Menses scanty or missed |
| 196 <input type="checkbox"/> Painful breasts during menses | 201 <input type="checkbox"/> Acne, worse at menses |

MALE ONLY

- | |
|---|
| 202 <input type="checkbox"/> Less involved in exercise/social activities |
| 203 <input type="checkbox"/> Difficult to postpone urination |
| 204 <input type="checkbox"/> Weak urinary stream |
| 205 <input type="checkbox"/> Feeling of "blues" or melancholy |
| 206 <input type="checkbox"/> Feeling of incomplete bowel evacuation |
| 207 <input type="checkbox"/> Lack of energy |
| 208 <input type="checkbox"/> Muscles in arms and legs seem softer/smaller |
| 209 <input type="checkbox"/> Tire too easily |
| 210 <input type="checkbox"/> Avoids activity |
| 211 <input type="checkbox"/> Leg nervousness at night |
| 212 <input type="checkbox"/> 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 MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row

MALES

Any 2 days during the month

RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.

Please list any medications you are taking:

☐ No Medications

Please list any vitamins, herbs, or supplements you are taking:

☐ No Vitamins

Please list any allergies you have:

☐ No Allergies

Please list any surgeries you have had in the past 12 months:

☐ 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 _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

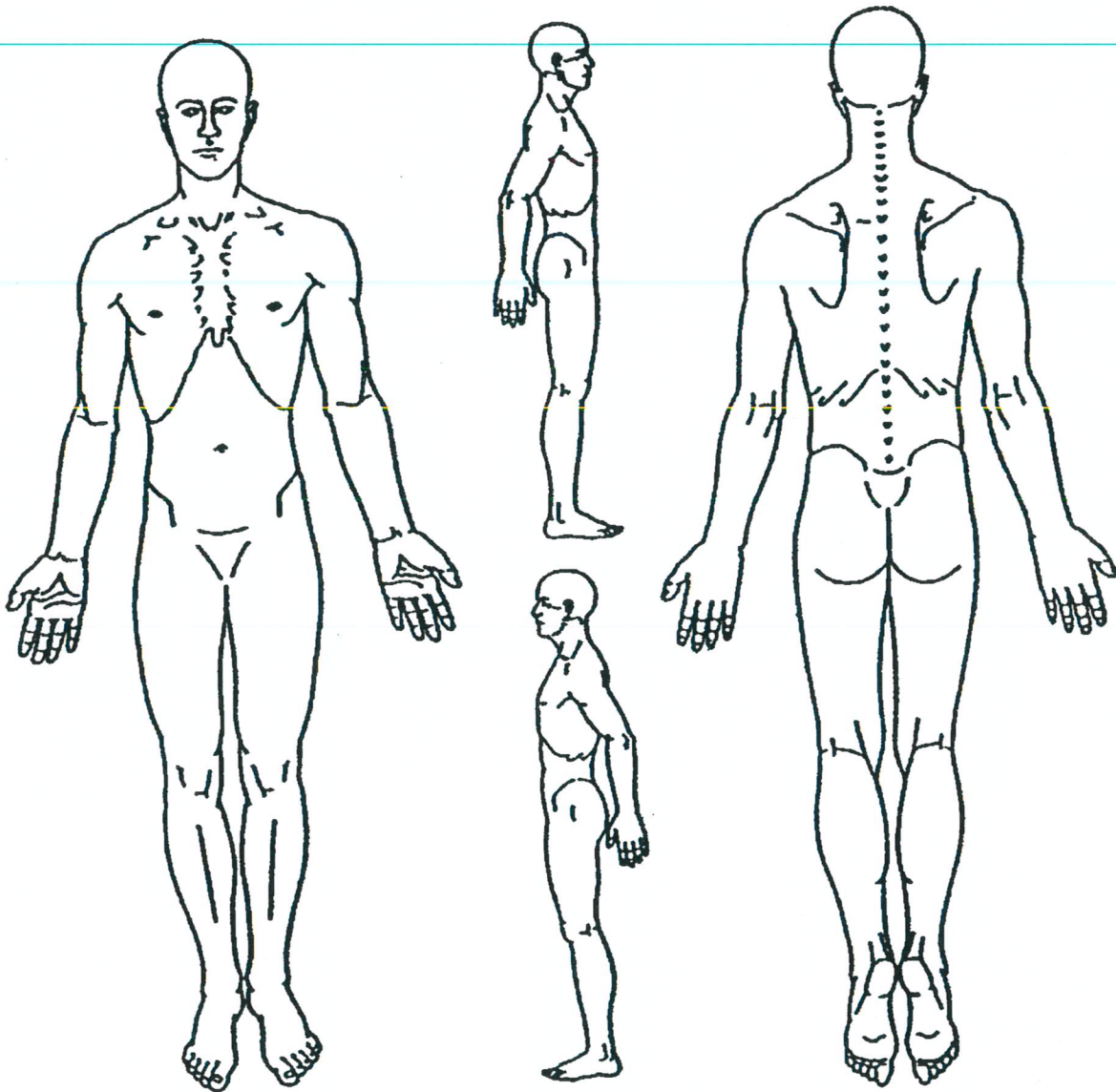
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYSTEMS SURVEY FORM - PAGE 5

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

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____