# 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 - Sympathetic Dominance

1 ☐ Acid foods upset
2 ☐ Get chilled often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meal
6 ☐ Keyed up - fail to calm
7 ☐ Cut heals slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
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 - Parasympathetic Dominance

21 ☐ Joint stiffness on arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

## GROUP 3 - Sugar Handling

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep - hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression - "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

## GROUP 4 - Cardio-Vascular

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed rooms
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles, worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black and blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head, or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

# SYSTEMS SURVEY FORM - PAGE 2

## GROUP 5 - Biliary / Liver

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

## GROUP 6 - Digestive

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

## GROUP 7 - Endocrine

### (A) - Hyperthyroid

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

### (B) - Hypothyroid

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Mental sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headaches upon arising, wear off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

### (C) - Hyperpituitary

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

### (D) - Hypopituitary

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

### (E) - Hyperadrenal

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

### (F) - Hypoadrenal

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increase
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies - tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion - muscular and nervous
172 ☐ Respiratory disorders

# SYSTEMS SURVEY FORM - PAGE 3

## GROUP 8 - Foundational

- 173 ☐ Muscle weakness
- 174 ☐ Lack of Stamina
- 175 ☐ Drowsiness after eating
- 176 ☐ Muscular soreness
- 177 ☐ Rapid heart beat
- 178 ☐ Hyper-irritable
- 179 ☐ Feeling of a band around your head
- 180 ☐ Melancholia (feeling of sadness)
- 181 ☐ Swelling of ankles
- 182 ☐ Diminished urination
- 183 ☐ Tendency to consume sweets or carbohydrates
- 184 ☐ Muscle spasms
- 185 ☐ Blurred vision
- 186 ☐ Loss of muscular control
- 187 ☐ Numbness
- 188 ☐ Night sweats
- 189 ☐ Rapid digestion
- 190 ☐ Sensitivity to noise
- 191 ☐ Redness of palms of hands and bottom of feet
- 192 ☐ Visible veins on chest and abdomen
- 193 ☐ Hemorrhoids
- 194 ☐ Apprehension (feeling that something bad will happen)
- 195 ☐ Nervousness causing loss of appetite
- 196 ☐ Nervousness with indigestion
- 197 ☐ Gastritis
- 198 ☐ Forgetfulness
- 199 ☐ Thinning hair

## FEMALE ONLY

- 200 ☐ Very easily fatigued
- 201 ☐ Premenstrual tension
- 202 ☐ Painful menses
- 203 ☐ Depressed feelings before menstruation
- 204 ☐ Menstruation excessive and prolonged
- 205 ☐ Painful breasts
- 206 ☐ Menstruate too frequently
- 207 ☐ Vaginal discharge
- 208 ☐ Hysterectomy/ovaries removed (write number 3)
- 209 ☐ Menopausal hot flashes
- 210 ☐ Menses scanty or missed
- 211 ☐ Acne, worse at menses
- 212 ☐ Depression of long standing

## MALE ONLY

- 213 ☐ Prostate trouble
- 214 ☐ Urination difficult or dribbling
- 215 ☐ Night urination frequent
- 216 ☐ Depression
- 217 ☐ Pain on inside of legs or heels
- 218 ☐ Feeling of incomplete bowel evacuation
- 219 ☐ Lack of energy
- 220 ☐ Migrating aches and pains
- 221 ☐ Tire too easily
- 222 ☐ Avoids activity
- 223 ☐ Leg nervousness at night
- 224 ☐ 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

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 | _____ |
| Date | _____ | Temperature | _____ |

# SYSTEMS SURVEY FORM - PAGE 4

**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 _____

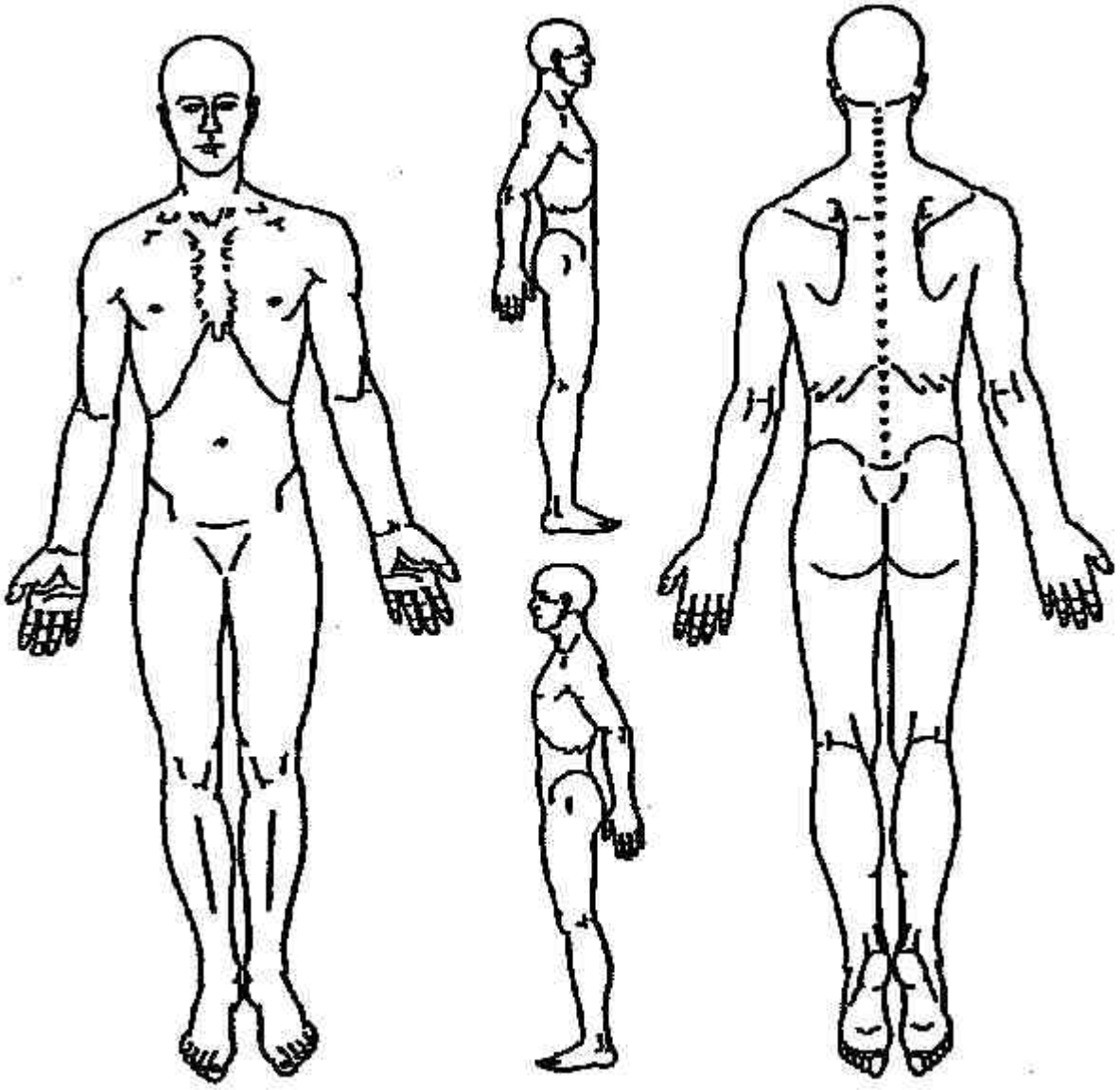
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

## 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 _____