PATIENT QUESTIONNAIRE

Symptom Survey

CENTER FOR ALTERNATIVE MEDICINE

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 (occurred once or twice last 6 months). ●○○

Fill in the circle marked 2 for **MODERATE** symptoms (occurred once or twice last month). ○●○

Fill in the circle marked 3 for **SEVERE** symptoms (chronic, occurred once or twice last week). ○○●

Leave circles BLANK if they don't apply to you! ○○○

GROUP ONE

	1	2	3	
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 TWO

	1	2	3	
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 THREE

	1	2	3	
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

Patient name: _____

GROUP FOUR

	1	2	3	
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

GROUP FIVE

	1	2	3	
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 SIX

	1	2	3	
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

Patient name: _____

GROUP SEVEN

(A)

	1	2	3	
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)

	1	2	3	
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)

	1	2	3	
137	○	○	○	Failing memory
138	○	○	○	Low blood pressure
139	○	○	○	Increased sex drive
140	○	○	○	Headaches, "splitting or rending" type
141	○	○	○	Decreased sugar tolerance

(D)

	1	2	3	
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)

	1	2	3	
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)

	1	2	3	
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

IMPORTANT

Please list the five main complaints you have in the order of their importance:

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

GROUP EIGHT

	1	2	3	
173	○	○	○	Apprehension
174	○	○	○	Irritability
175	○	○	○	Morbid fears
176	○	○	○	Never seems to get well
177	○	○	○	Forgetfulness
178	○	○	○	Indigestion
179	○	○	○	Poor appetite
180	○	○	○	Craving for sweets
181	○	○	○	Muscular soreness
182	○	○	○	Depression; feelings of dread
183	○	○	○	Noise sensitivity
184	○	○	○	Acoustic hallucinations
185	○	○	○	Tendency to cry without reason
186	○	○	○	Hair is coarse and/or thinning
187	○	○	○	Weakness
188	○	○	○	Fatigue
189	○	○	○	Skin sensitive to touch
190	○	○	○	Tendency toward hives
191	○	○	○	Nervousness
192	○	○	○	Headache
193	○	○	○	Insomnia
194	○	○	○	Anxiety
195	○	○	○	Anorexia
196	○	○	○	Inability to concentrate; confusion
197	○	○	○	Frequent stuffy nose; sinus infections
198	○	○	○	Allergy to some foods
199	○	○	○	Loose joints

FEMALE ONLY

	1	2	3	
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
209	○	○	○	Menopausal hot flashes
210	○	○	○	Menses scanty or missed
211	○	○	○	Acne, worse at menses
212	○	○	○	Depression of long standing

MALE ONLY

	1	2	3	
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

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	_____

MEDICATIONS, SUPPLEMENTS & HISTORY

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 _____

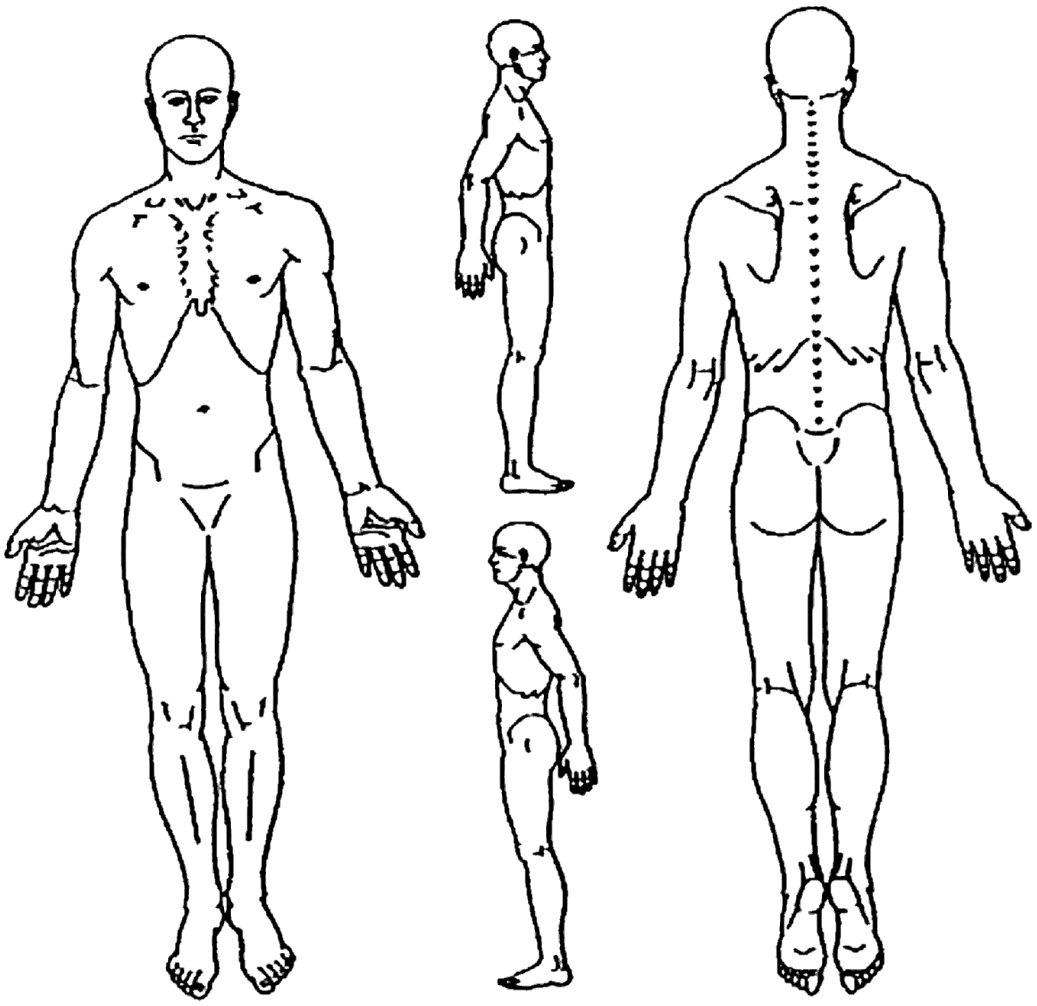
Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

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

Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

Patient name: _____

PAIN AND SENSATIONS



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 ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 SEVERE PAIN

PATIENT SIGNATURE

DATE