

Systems Survey Form (page 1 of 4)

Name: _____

Date: _____

Sex: M__ F__

INSTRUCTIONS: Fill in only the circles which apply to you.

- □ □ MILD symptoms (occurs rarely)
- ■ □ MODERATE symptoms (occurs several times a month)
- □ ■ SEVERE symptoms (occurs almost constantly)
- □ □ Leave circles BLANK if they don't apply to you

	1 2 3	GROUP 1		1 2 3	GROUP 2 (continued)
1	□ □ □	Acid foods upset	37	□ □ □	"Slow starter"
2	□ □ □	Get chilled often	38	□ □ □	Get "chilled" infrequently, seldom
3	□ □ □	"Lump" in throat	39	□ □ □	Perspire easily
4	□ □ □	Dry mouth-eyes-nose	40	□ □ □	Circulation poor, sensitive to cold
5	□ □ □	Pulse speeds after meal	41	□ □ □	Subject to colds, asthma, bronchitis
6	□ □ □	Keyed up – fail to calm			
7	□ □ □	Cut heals slowly		1 2 3	GROUP 3
8	□ □ □	Gag easily	42	□ □ □	Eat when nervous
9	□ □ □	Unable to relax; startles easily	43	□ □ □	Excessive appetite
10	□ □ □	Extremities cold, clammy	44	□ □ □	Hungry between meals
11	□ □ □	Strong light irritates	45	□ □ □	Irritable before meals
12	□ □ □	Urine amount reduced	46	□ □ □	Get "shaky" if hungry
13	□ □ □	Heart pounds after retiring	47	□ □ □	Fatigue, eating relieves
14	□ □ □	"Nervous" stomach	48	□ □ □	"Lightheaded" if meals delayed
15	□ □ □	Appetite reduced	49	□ □ □	Heart palpitates if meals missed or delayed
16	□ □ □	Cold sweats often	50	□ □ □	Afternoon headaches
17	□ □ □	Fever easily raised	51	□ □ □	Overeating sweets upsets
18	□ □ □	Neuralgia-like pains	52	□ □ □	Awaken after few hours sleep – hard to get back to sleep
19	□ □ □	Staring, blinks little			
20	□ □ □	Sour stomach often	53	□ □ □	Crave candy or coffee in afternoons
			54	□ □ □	Moods of depression - "blues" or melancholy
	1 2 3	GROUP 2			
21	□ □ □	Joint stiffness on arising	55	□ □ □	Abnormal craving for sweets or snacks
22	□ □ □	Muscle-leg-toe cramps at night			
23	□ □ □	"Butterfly" stomach, cramps		1 2 3	GROUP 4
24	□ □ □	Eyes or nose watery	56	□ □ □	Hands and feet go to sleep easily, numbness
25	□ □ □	Eyes blink often	57	□ □ □	Sigh frequently, "air hunger"
26	□ □ □	Eyelids swollen, puffy	58	□ □ □	Aware of "breathing heavily"
27	□ □ □	Indigestion soon after meals	59	□ □ □	High altitude discomfort
28	□ □ □	Always seems hungry; feels "lightheaded" often	60	□ □ □	Opens windows in closed rooms
			61	□ □ □	Susceptible to colds and fevers
29	□ □ □	Digestion rapid	62	□ □ □	Afternoon "yawner"
30	□ □ □	Vomiting frequent	63	□ □ □	Get "drowsy" often
31	□ □ □	Hoarseness frequent	64	□ □ □	Swollen ankles, worse at night
32	□ □ □	Breathing irregular	65	□ □ □	Muscle cramps, worse during exercise; get "charley horses"
33	□ □ □	Pulse slow; feels "irregular"			
34	□ □ □	Gagging reflex slow	66	□ □ □	Shortness of breath on exertion
35	□ □ □	Difficulty swallowing	67	□ □ □	Dull pain in chest or radiating into left arm, worse on exertion ▼
36	□ □ □	Constipation, diarrhea alternating			

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	1	2	3	GROUP 4 (continued)		1	2	3	GROUP 6 (continued)
68	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily, "black and blue" spots	100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning stomach sensations, eating relieves
					101				Coated tongue
69	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to anemia	102	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pass large amounts of foul-smelling gas
70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Nose bleeds" frequent	103	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion ½-1hr after eating, may be up to 3-4 hours
71	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Noises in head, or "ringing in ears"					
72	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension under the breastbone, or feeling of "tightness", worse on exertion	104	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucous colitis or "irritable bowel"
					105				Gas shortly after eating
					106				Stomach "bloating" after eating
	1	2	3	GROUP 5		1	2	3	GROUP 7A
73	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	107	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
74	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	108	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning feet	109	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't gain weight
76	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	110	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to heat
77	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching skin and feet	111	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Highly emotional
78	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive falling hair	112	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flush easily
79	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent skin rashes	113	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bitter, metallic taste in mouth in a.m.	114	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thin, moist skin
81	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements painful or difficult	115	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inward trembling
					116				Heart palpitates
82	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worrier, feels insecure	117	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite without weight gain
83	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling queasy; headache over eyes	118	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulse fast at rest
84	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Greasy foods upset	119	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyelids and face twitch
85	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stools light colored	120	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable and restless
86	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin peels on foot soles	121	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't work under pressure
87	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulder blades					
88	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use laxatives		1	2	3	GROUP 7B
89	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stools alternate from soft to watery	122	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increase in weight
90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of gallbladder attacks or gallstones	123	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decrease in appetite
					124				Fatigue easily
91	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing attacks	125	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringling in ears
92	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dreaming nightmares, bad dreams	126	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy during day
93	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath (halitosis)	127	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold
94	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Milk products cause distress	128	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry or scaly skin
95	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot weather	129	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
96	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning or itching anus	130	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental sluggishness
97	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave sweets	131	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair coarse, falls out
					132				Headaches upon arising, wear off during day
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GROUP 6	133	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow pulse, below 65
98	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste for meat	134	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequency of urination
99	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower bowel gas several hours after eating	135	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impaired hearing
					136				Reduced initiative
									▼

Symptoms Survey Form (page 3 of 4)

	1 2 3	GROUP 7C		1 2 3	GROUP 8
137	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Failing memory	173	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Apprehension
138	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Low blood pressure	174	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Irritability
139	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Increased sex drive	175	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Morbid fears
140	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headaches, "splitting" type	176	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Never seems to get well
141	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Decreased sugar tolerance	177	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Forgetfulness
			178	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Indigestion
	1 2 3	GROUP 7D	179	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor appetite
142	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Abnormal thirst	180	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Craving for sweets
143	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bloating of abdomen	181	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Muscular soreness
144	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Weight gain around hips or waist	182	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depression; feelings of dread
145	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sex drive reduced or lacking	183	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Noise sensitivity
146	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tendency to ulcers, colitis	184	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Acoustic hallucinations
147	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Increased sugar tolerance	185	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tendency to cry without reason
148	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Women: menstrual disorders	186	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hair is coarse and/or thinning
149	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Young girls: lack of menstrual function	187	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Weakness
			188	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fatigue
	1 2 3	GROUP 7E	189	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Skin sensitive to touch
150	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness	190	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tendency toward hives
151	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headaches	191	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nervousness
152	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hot flashes	192	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headache
153	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Increased blood pressure	193	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Insomnia
154	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hair growth on face or body (female)	194	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anxiety
155	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sugar in urine (not diabetes)	195	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anorexia
156	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Masculine tendencies (female)	196	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Inability to concentrate; confusion
			197	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequent stuffy nose; sinus infections
	1 2 3	GROUP 7F	198	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Allergy to some foods
157	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Weakness, dizziness	199	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Loose Joints
158	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic fatigue			
159	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Low blood pressure		1 2 3	FEMALE ONLY
160	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nails weak, rigid	200	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Very easily fatigued
161	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tendency to hives	201	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Premenstrual tension
162	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritic tendencies	202	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful menses
163	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Perspiration increase	203	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depressed feelings before menstruation
164	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bowel disorders	204	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Menstruation excessive and prolonged
165	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor circulation	205	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful breasts
166	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Swollen ankles	206	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Menstruate too frequently
167	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Crave salt	207	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vaginal discharge
168	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Brown spots or bronzing of skin	208	<input type="checkbox"/>	Hysterectomy / ovaries removed
169	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Allergies – tendency to asthma	209	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Menopausal hot flashes
170	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Weakness after colds, influenza	210	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Menses scanty or missed
171	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Exhaustion – muscular and nervous	211	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Acne, worse at menses
172	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Respiratory disorders	212	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depression of long standing
					▼

Symptoms Survey Form (page 4 of 4)

	1	2	3	MALE ONLY	List the five main complaints you have in the order of their importance:
213	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble	
214	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urination difficult or dribbling	
215	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night urination frequent	
216	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	2.
217	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain on inside of legs or heels	
218	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling of incomplete bowel evacuation	3.
219	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	
220	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migrating aches and pains	4.
221	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tire too easily	
222	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoids activity	5.
223	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg nervousness at night	
224	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diminished sex drive	