

PATIENT SYMPTOM SURVEY

DATE_____

PATIENT'S NAME_____ AGE_____

WEIGHT_____ HEIGHT_____ BP_____ PULSE_____ %O2_____ BodyFat_____

This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

- | | | |
|---|--|--|
| 090 <input type="checkbox"/> General Good Health | 042 <input type="checkbox"/> Numbness 782.0 | 072 <input type="checkbox"/> Infertility, female 628.9 |
| 091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis | 043 <input type="checkbox"/> Constipation 564.0 | 073 <input type="checkbox"/> Interstitial Cystitis |
| 001 <input type="checkbox"/> Skin Disorder 692.9 | 044 <input type="checkbox"/> Indigestion 536.8 | 074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4 |
| 002 <input type="checkbox"/> Acne 706.1 | 045 <input type="checkbox"/> Ulcerative Colitis 556.9 | 075 <input type="checkbox"/> Menopausal Symptoms 627.2 |
| 003 <input type="checkbox"/> Psoriasis 696.1 | 046 <input type="checkbox"/> Depression 311.0 | 076 <input type="checkbox"/> Hot Flashes 627.2 |
| 004 <input type="checkbox"/> Urticaria (Hives) 708.9 | 047 <input type="checkbox"/> Diabetes Mellitus 250.0 | 077 <input type="checkbox"/> Mental Disorder |
| 005 <input type="checkbox"/> ADD/ADHD 314.01 | 048 <input type="checkbox"/> Hypoglycemia 251.2 | 078 <input type="checkbox"/> Insomnia 780.52 |
| 006 <input type="checkbox"/> Allergies 477.0 | 049 <input type="checkbox"/> Dizziness/Balance Problem 780.4 | 079 <input type="checkbox"/> Mouth/Throat/Tongue |
| 007 <input type="checkbox"/> Food Allergy 691.8 | 050 <input type="checkbox"/> Ear Infection 386.30 | 080 <input type="checkbox"/> Canker Sores 528.2 |
| 008 <input type="checkbox"/> Sinusitis 461.9 | 051 <input type="checkbox"/> Epstein Barr 075.0 | 081 <input type="checkbox"/> Overweight 278.0 |
| 009 <input type="checkbox"/> Alzheimer's 333.1 | 052 <input type="checkbox"/> Eye Problems 379.91 | 082 <input type="checkbox"/> Underweight 783.2 |
| 010 <input type="checkbox"/> Poor Concentration/Memory 310.1 | 053 <input type="checkbox"/> Cataracts 366.9 | 083 <input type="checkbox"/> Sexual Disorder 302.9 |
| 011 <input type="checkbox"/> Parkinson's Disease | 054 <input type="checkbox"/> Glaucoma 365.62 | 084 <input type="checkbox"/> Spinal Problems |
| 012 <input type="checkbox"/> Anemia 285.9 | 055 <input type="checkbox"/> Macular Degeneration 362.5 | 085 <input type="checkbox"/> Obesity 278.0 |
| 013 <input type="checkbox"/> Arthritic Disorder 716.9 | 056 <input type="checkbox"/> Fever 780.6 | 086 <input type="checkbox"/> GERD 530.81 |
| 014 <input type="checkbox"/> Osteoporosis 733.0 | 057 <input type="checkbox"/> Fibromyalgia 729.1 | 087 <input type="checkbox"/> HIV infection |
| 015 <input type="checkbox"/> Asthma 493.9 | 058 <input type="checkbox"/> Gallbladder Disorder 575.9 | 017 <input type="checkbox"/> Cancer |
| 016 <input type="checkbox"/> Emphysema 492.8 | 059 <input type="checkbox"/> Gout 274.9 | 018 <input type="checkbox"/> Breast 174.9 |
| 035 <input type="checkbox"/> Chronic Fatigue 780.71 | 060 <input type="checkbox"/> Headaches 784.0 | 019 <input type="checkbox"/> Prostate 185.0 |
| 036 <input type="checkbox"/> Circulatory Disorder 459.90 | 061 <input type="checkbox"/> Hearing Loss 389.90 | 020 <input type="checkbox"/> Lung 162.9 |
| 037 <input type="checkbox"/> Heart Disease 429.90 | 062 <input type="checkbox"/> Infertility, male 606.9 | 021 <input type="checkbox"/> Colon/Rectal 153.9 |
| 038 <input type="checkbox"/> High Cholesterol 272.0 | 063 <input type="checkbox"/> Prostate Disorder 602.9 | 022 <input type="checkbox"/> Skin 173.9 |
| 039 <input type="checkbox"/> High Blood Pressure 401.9 | 064 <input type="checkbox"/> Liver Disease 571.9 | 023 <input type="checkbox"/> Leukemia |
| 040 <input type="checkbox"/> Low Blood Pressure 458.9 | 065 <input type="checkbox"/> Hepatitis 573.3 | 024 <input type="checkbox"/> Lymphoma |
| 041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00 | 066 <input type="checkbox"/> Hepatitis B | 025 <input type="checkbox"/> Brain Tumor 191.9 |
| | 067 <input type="checkbox"/> Hepatitis C | 026 <input type="checkbox"/> Other |
| | 068 <input type="checkbox"/> Kidney/Bladder Problems | 088 <input type="checkbox"/> Crohn's Disease 555.9 |
| | 069 <input type="checkbox"/> Hyperthyroid 242.9 | 089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1 |
| | 070 <input type="checkbox"/> Hypothyroid 244.9 | |
| | 071 <input type="checkbox"/> Lupus 710.0 | |

If necessary, please state your most significant concern.

General Health

- | | | |
|---|--|---|
| 100 <input type="checkbox"/> Base of fingernails are pink | 113 <input type="checkbox"/> Thin hair | 124 <input type="checkbox"/> Unexplained weight loss of over 20lbs within the last 4 months |
| 101 <input type="checkbox"/> Base of fingernails are purple | 114 <input type="checkbox"/> Hair loss | 125 <input type="checkbox"/> Energy level is worse than it was 5 years ago |
| 102 <input type="checkbox"/> Fingernails have ridges or white spots | 115 <input type="checkbox"/> Drinks alcoholic beverages daily | 127 <input type="checkbox"/> Sleeps less than 6 hours per night |
| 103 <input type="checkbox"/> Fingernails are soft | 116 <input type="checkbox"/> Drinks less than 8 glasses of water per day | 128 <input type="checkbox"/> Unable to recall dreams the next day |
| 104 <input type="checkbox"/> Fingernails are splitting | 117 <input type="checkbox"/> Currently on Chemotherapy | 129 <input type="checkbox"/> Sensitive to chemicals, paint, fumes, cologne |
| 105 <input type="checkbox"/> Fingernails peel | 118 <input type="checkbox"/> Currently on radiation treatment | 130 <input type="checkbox"/> Had blood transfusion in the past |
| 106 <input type="checkbox"/> Pale fingernail beds | 119 <input type="checkbox"/> Had chemotherapy in the past | 131 <input type="checkbox"/> Had transplant in the past |
| 107 <input type="checkbox"/> Blacks out easily | 120 <input type="checkbox"/> Has had radiation treatments in the past | 132 <input type="checkbox"/> Had a major accident or injury (i.e. auto, work, other) |
| 108 <input type="checkbox"/> Balance problems | 121 <input type="checkbox"/> Gained over 20 lbs in the last 12 months | |
| 109 <input type="checkbox"/> Difficulty walking | 122 <input type="checkbox"/> Somewhat Overweight | |
| 110 <input type="checkbox"/> Has tattoos | 123 <input type="checkbox"/> Somewhat Underweight | |
| 111 <input type="checkbox"/> Brittle hair | | |
| 112 <input type="checkbox"/> Dry hair | | |

Lifestyle Habits

- | | | |
|--|--|--|
| 370 <input type="checkbox"/> Drinks alcohol | 378 <input type="checkbox"/> Drinks more than 3 cups of tea per day | 384 <input type="checkbox"/> Smoked for more than 5 years |
| 371 <input type="checkbox"/> Drinks caffeinated coffee | 379 <input type="checkbox"/> Drinks 1 or more pop/sodas per day | 385 <input type="checkbox"/> Smokes more than 1 pack per day |
| 372 <input type="checkbox"/> Drinks caffeinated pop/soda | 388 <input type="checkbox"/> Drinks diet pop/soda | 126 <input type="checkbox"/> Rarely exercises |
| 373 <input type="checkbox"/> Drinks caffeinated tea | 380 <input type="checkbox"/> Drinks beverages from a can | 133 <input type="checkbox"/> Regularly exercises |
| 374 <input type="checkbox"/> Drinks decaffeinated coffee | 381 <input type="checkbox"/> Has more than 5 alcoholic drinks per week | 386 <input type="checkbox"/> Takes Vitamins |
| 375 <input type="checkbox"/> Drinks decaffeinated pop/soda | 382 <input type="checkbox"/> Currently smokes | 134 <input type="checkbox"/> Vegetarian |
| 376 <input type="checkbox"/> Drinks decaffeinated tea | 383 <input type="checkbox"/> Quit smoking in the last 5 years | 135 <input type="checkbox"/> Eats no red meat |
| 377 <input type="checkbox"/> Drinks more than 3 cups of coffee per day | | 136 <input type="checkbox"/> Eats no meat, no dairy |
| | | 387 <input type="checkbox"/> Frequent use of artificial sweeteners |

Surgeries

- | | | |
|--|---|--|
| 700 <input type="checkbox"/> Tonsillectomy and/or Adenoids | 708 <input type="checkbox"/> Cancer | 709 <input type="checkbox"/> Coronary by-pass |
| 701 <input type="checkbox"/> Appendix | 704 <input type="checkbox"/> Hysterectomy, complete | 710 <input type="checkbox"/> Spinal surgery |
| 702 <input type="checkbox"/> Gallbladder | 705 <input type="checkbox"/> Hysterectomy, partial | 711 <input type="checkbox"/> Extremity surgery |
| 703 <input type="checkbox"/> Thyroid | 706 <input type="checkbox"/> Tubal ligation | 712 <input type="checkbox"/> Hip replacement |
| 715 <input type="checkbox"/> Radiated thyroid | 707 <input type="checkbox"/> Breast implants | 713 <input type="checkbox"/> Knee replacement |

Gastrointestinal

- | | | |
|---|---|--|
| 265 <input type="checkbox"/> 4-5 bowel movements per week | 277 <input type="checkbox"/> Abdominal gas | 289 <input type="checkbox"/> Eats when nervous |
| 266 <input type="checkbox"/> 3 or less bowel movements per week | 278 <input type="checkbox"/> Belching and burping after eating | 290 <input type="checkbox"/> Excessive hunger |
| 267 <input type="checkbox"/> 6 or more bowel movements per week | 279 <input type="checkbox"/> Bloating after eating | 291 <input type="checkbox"/> Poor appetite |
| 268 <input type="checkbox"/> Black tarry stools | 280 <input type="checkbox"/> Severe abdominal pains | 292 <input type="checkbox"/> Experiences fainting spells when hungry |
| 269 <input type="checkbox"/> Pale or yellow colored stool | 281 <input type="checkbox"/> Stomach ulcers | 293 <input type="checkbox"/> Feels shaky when hungry |
| 270 <input type="checkbox"/> Blood stools | 282 <input type="checkbox"/> Uses digestive aids | 294 <input type="checkbox"/> Frequently drowsy after eating a meal |
| 271 <input type="checkbox"/> Constipation | 283 <input type="checkbox"/> Uses laxatives | 295 <input type="checkbox"/> Gall bladder disease |
| 272 <input type="checkbox"/> Hemorrhoids | 284 <input type="checkbox"/> Immediate indigestion upon eating | 296 <input type="checkbox"/> Has had intestinal worms |
| 273 <input type="checkbox"/> Loose bowel movements | 285 <input type="checkbox"/> Indigestion in 2 hours or more after meals | 297 <input type="checkbox"/> Reflux/Hiatal hernia |
| 274 <input type="checkbox"/> Frequent diarrhea | 286 <input type="checkbox"/> Indigestion within 1 hour after meals | 298 <input type="checkbox"/> Liver disease |
| 275 <input type="checkbox"/> Frequent nausea | 287 <input type="checkbox"/> Difficulty swallowing | 299 <input type="checkbox"/> Irritable Bowel Syndrome |
| 276 <input type="checkbox"/> Frequent vomiting | 288 <input type="checkbox"/> Eating relieves fatigue | |

Respiratory

- | | | |
|--|--|--|
| 485 <input type="checkbox"/> Catches severe colds | 491 <input type="checkbox"/> Frequent colds | 497 <input type="checkbox"/> Night sweats |
| 486 <input type="checkbox"/> Chronic chest condition | 492 <input type="checkbox"/> Frequent nose bleeds | 498 <input type="checkbox"/> Post nasal drip |
| 487 <input type="checkbox"/> Chronic cough | 493 <input type="checkbox"/> Frequent sinus infections | 499 <input type="checkbox"/> Sneezing spells |
| 488 <input type="checkbox"/> Constant runny nose | 494 <input type="checkbox"/> Frequent stuffy nose | 500 <input type="checkbox"/> Spits up blood |
| 489 <input type="checkbox"/> COPD | 495 <input type="checkbox"/> Hay fever | 501 <input type="checkbox"/> Spits up phlegm |
| 490 <input type="checkbox"/> Difficulty breathing | 496 <input type="checkbox"/> Nasal polyps | 502 <input type="checkbox"/> Wheezes |

Mouth and Throat

- | | | |
|--|---|---|
| 400 <input type="checkbox"/> Bad breath | 407 <input type="checkbox"/> Frequent fever blisters | 415 <input type="checkbox"/> Tongue is coated |
| 401 <input type="checkbox"/> Bitter taste in the mouth in the morning | 408 <input type="checkbox"/> Frequent sore throats | 416 <input type="checkbox"/> Gums bleed when brushing teeth |
| 402 <input type="checkbox"/> Dry mouth | 409 <input type="checkbox"/> Frequently has a sore tongue | 417 <input type="checkbox"/> Toothaches |
| 403 <input type="checkbox"/> Excessive saliva | 410 <input type="checkbox"/> Sore gums | 418 <input type="checkbox"/> Amalgam dental fillings |
| 404 <input type="checkbox"/> Sores or cracks in the corners of the mouth | 411 <input type="checkbox"/> Swollen gums | 420 <input type="checkbox"/> Other dental fillings (gold, composite, etc) |
| 405 <input type="checkbox"/> Glands often swell | 412 <input type="checkbox"/> Swollen tongue | 419 <input type="checkbox"/> Has had root canal(s) |
| 406 <input type="checkbox"/> Frequent canker sores | 413 <input type="checkbox"/> Tongue burns | |
| | 414 <input type="checkbox"/> Tongue has grooves or fissures | |

Endocrine

- | | | |
|---|---|---|
| 245 <input type="checkbox"/> Coarse hair | 249 <input type="checkbox"/> Frequently feels cold | 253 <input type="checkbox"/> Unusually jumpy or nervous |
| 246 <input type="checkbox"/> Coarse skin | 250 <input type="checkbox"/> Frequently feels hot | 254 <input type="checkbox"/> Unusually tired most of the time |
| 247 <input type="checkbox"/> Diabetic | 251 <input type="checkbox"/> Gets lightheaded when standing quickly | |
| 248 <input type="checkbox"/> Excessive thirst | 252 <input type="checkbox"/> Heals slowly | |

Cardiovascular

- 190 Cold feet
- 191 Cold hands
- 192 Experiences shortness of breath while sitting still
- 193 Heart skips beats
- 194 Tendency of High blood pressure
- 195 Leg cramps during bedtime
- 196 Leg cramps during daytime
- 197 Low blood pressure at times
- 198 Pain in leg/hips when walking
- 199 Frequent swollen ankles
- 200 Pains in the heart or chest
- 201 Spells of rapid heart rate
- 202 Troubled with blood clots
- 203 Unusually slow pulse rate
- 204 Varicose veins

Skin

- 520 Bruises easily
- 521 Excessive perspiration
- 522 Frequent goose bumps
- 523 Has acne
- 524 Has Psoriasis
- 525 Hives
- 526 Itchy skin
- 527 Problems with Eczema
- 528 Has moles which are changing in size and/or color
- 529 Skin eruptions
- 530 Skin is rough, especially on the back of the arms
- 531 Skin is tender
- 532 Sores that heal slowly
- 533 Troubled with boils
- 534 Dry skin

Ears

- 220 Discharge from ears
- 221 Hard of hearing
- 222 Punctured ear drum
- 223 Recurrent ear infection
- 224 Ringing or noises in the ears

Eyes

- 320 Bloodshot eyes
- 321 Blurred vision
- 322 Cross eyes
- 323 Eye pain
- 324 Eyes feel gritty
- 325 Eyes watery
- 326 Mild Glaucoma
- 327 Far sighted
- 328 Developing cataracts
- 329 Mild Macular degeneration
- 330 Itchy eyes
- 331 Near sighted
- 332 Dry Eyes

Feet

- 350 Corns
- 351 Frequent foot cramps
- 352 Heel spurs
- 353 Painful feet
- 354 Plantar warts
- 355 Swelling in the feet and/or ankles
- 356 Plantar fasciitis
- 357 Fungal Infection

Neuromuscular

- 440 Bites nails
- 441 Frequent muscle soreness
- 442 Muscle spasms
- 443 Muscle weakness
- 444 Tremors
- 445 Frequent headaches
- 446 Often dizzy
- 447 Frequently feels faint
- 448 Has Epilepsy
- 449 Has motion sickness
- 450 Has Osteoarthritis
- 451 Has Rheumatism
- 452 Rheumatoid Arthritis
- 453 Joint stiffness in the morning
- 454 Swollen joints
- 455 Leg pain at rest
- 456 Spinal curvature
- 457 Low back pain
- 458 Neck pain
- 459 Pain between the shoulders
- 460 Shoulder/arm pain
- 461 Numbness/tingling in the body
- 462 Sleep walks
- 463 Stutters or stammers
- 464 Nerve pain

Behavior Patterns

- 150 Afraid to eat anywhere except home
151 Always needs someone to advise
152 Cries often
153 Difficulty concentrating
154 Difficulty falling asleep
155 Difficulty staying asleep
156 Easily angered
157 Feelings are easily hurt
158 Frequently becomes scared for no reason
159 Frequently miserable or blue
160 Has to be on guard even with friends
161 Often annoyed by people
162 Recurrent bad dreams
163 Sometimes wishes to be dead or away from it all
164 Upset by criticism
165 Poor memory
166 Scared to be alone
167 Strange people or places cause fear
168 Under considerable emotional stress
169 Unhappy when other are happy
170 Brain fog

Urinary

- 555 Urinates more than 2 times per night
556 Bed wetting
557 Blood in the urine
558 Difficulty starting urination
559 Painful urination
560 Frequent urination
561 Troubled by urgent urination
562 Incontinence when sneezing or laughing
563 Loses bladder control
564 Frequent bladder infections
565 Frequent kidney infections
566 Kidney stones

Men Only

- 585 Difficulty completing intercourse
586 Difficulty getting or keeping an erection
587 Discharge from the urethra
588 Had a vasectomy
589 Had difficulty fathering children
590 Lumps in the testicles
591 Painful genitals
592 Prostate troubles
593 Sores on external genitalia
594 Herpes
595 Sexual diseases

Women Only

- 610 Heavy hair growth on face or body
611 Cycles are every 27-29 days
612 Abnormal cycle >29 days and/or <26 days
613 PMS
614 Menstrual cramps
615 Painful periods
616 Acne worse at menstruation
617 Excessive menstrual flow
618 Retains fluid during periods
619 Pre-menstrual depression
620 Currently taking birth control medication
621 Has taken birth control medication more than 1 year
622 Has taken birth control medication within the last year
623 Has had miscarriage
624 Hot flashes
625 Takes hormone replacement medication
627 Diminished sexual desire
628 Painful intercourse
629 Poor or infrequent orgasm
630 Lumps in the breasts
631 Tender breasts
633 Vaginal discharge
634 Bloody spotting discharge
635 Yeast infections
636 Sores on external genitalia
637 Herpes
638 Sexual diseases

Medications

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.

<u>VITAMIN/HOW MUCH</u>		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____