

Systems Survey Form | Restricted to Professional Use



NAME: _____ AGE: _____ HEALTH CARE PROFESSIONAL: _____ DATE: _____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

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

GROUP 2

20.	1 2 3	Joint stiffness after arising
21.	1 2 3	Muscle, leg, toe cramps at night
22.	1 2 3	"Butterfly" stomach, cramps
23.	1 2 3	Eyes or nose watery
24.	1 2 3	Eyes blink often
25.	1 2 3	Eyelids swollen, puffy
26.	1 2 3	Indigestion soon after meals
27.	1 2 3	Always seem hungry, feel "lightheaded" often
28.	1 2 3	Digestion rapid
29.	1 2 3	Vomit occasionally
30.	1 2 3	Hoarseness frequent
31.	1 2 3	Uneven breathing
32.	1 2 3	Pulse slow
33.	1 2 3	Gagging reflex slow
34.	1 2 3	Difficulty swallowing
35.	1 2 3	Temporary constipation or diarrhea
36.	1 2 3	"Slow starter"
37.	1 2 3	Get "chilled"
38.	1 2 3	Perspire easily
39.	1 2 3	Sensitive to cold
40.	1 2 3	Upper respiratory challenges
_____		TOTAL
1	2	3

GROUP 3

41.	1 2 3	Eat when nervous
42.	1 2 3	Excessive appetite
43.	1 2 3	Hungry between meals
44.	1 2 3	Irritable before meals

45.	1 2 3	Get "shaky" if hungry
46.	1 2 3	Fatigue, eating relieves
47.	1 2 3	"Lightheaded" if meals delayed
48.	1 2 3	Heart palpitates if meals missed or delayed
49.	1 2 3	Fatigue in afternoon
50.	1 2 3	Overeating sweets upsets
51.	1 2 3	Awaken after few hours sleep, hard to get back to sleep
52.	1 2 3	Crave candy or coffee in afternoon
53.	1 2 3	Moods of "blues" or melancholy
54.	1 2 3	Craving for sweets or snacks
_____		TOTAL
1	2	3

GROUP 4

55.	1 2 3	Hands and feet go to sleep easily, numbness
56.	1 2 3	Sigh frequently, "air hunger"
57.	1 2 3	Aware of "breathing heavily"
58.	1 2 3	High-altitude discomfort
59.	1 2 3	Open windows in closed room
60.	1 2 3	Immune system challenges
61.	1 2 3	Afternoon "yawner"
62.	1 2 3	Get "drowsy" often
63.	1 2 3	Swollen ankles worse at night
64.	1 2 3	Muscle cramps, worse during exercise; get "charley horse"
65.	1 2 3	Difficulty catching breath, especially during exercise
66.	1 2 3	Tightness or pressure in chest, worse on exertion
67.	1 2 3	Skin discolors easily after impact
68.	1 2 3	Tendency to anemia
69.	1 2 3	Noises in head or "ringing in ears"
70.	1 2 3	Fatigue upon exertion
_____		TOTAL
1	2	3

GROUP 5

71.	1 2 3	Dizziness
72.	1 2 3	Dry skin
73.	1 2 3	Burning feet
74.	1 2 3	Blurred vision
75.	1 2 3	Itching skin and feet
76.	1 2 3	Hair loss
77.	1 2 3	Occasional skin rashes
78.	1 2 3	Bitter, metallic taste in mouth in morning
79.	1 2 3	Occasional constipation
80.	1 2 3	Worrier, feels insecure
81.	1 2 3	Nausea occasionally after eating
82.	1 2 3	Greasy foods upset
83.	1 2 3	Stools light-colored
84.	1 2 3	Skin peels on foot soles

85.	1 2 3	Discomfort between shoulder blades
86.	1 2 3	Occasional laxative use
87.	1 2 3	Stools alternate from soft to watery
88.	1 2 3	Sneezing attacks
89.	1 2 3	Dreaming, nightmare-type bad dreams
90.	1 2 3	Bad breath (halitosis)
91.	1 2 3	Milk products cause upset
92.	1 2 3	Sensitive to hot weather
93.	1 2 3	Burning or itching anus
94.	1 2 3	Crave sweets
_____		TOTAL
1	2	3

GROUP 6

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

GROUP 7A

104.	1 2 3	Difficulty sleeping
105.	1 2 3	On edge
106.	1 2 3	Can't gain weight
107.	1 2 3	Intolerance to heat
108.	1 2 3	Highly emotional
109.	1 2 3	Flush easily
110.	1 2 3	Night sweats
111.	1 2 3	Thin, moist skin
112.	1 2 3	Inward trembling
113.	1 2 3	Heart races
114.	1 2 3	Increased appetite without weight gain
115.	1 2 3	Pulse fast at rest
116.	1 2 3	Eyelids and face twitch
117.	1 2 3	Irritable and restless
118.	1 2 3	Can't work under pressure
_____		TOTAL
1	2	3

GROUP 7B

- 119. 1 2 3 Increase in weight
- 120. 1 2 3 Decrease in appetite
- 121. 1 2 3 Fatigue easily
- 122. 1 2 3 Ringing in ears
- 123. 1 2 3 Sleepy during day
- 124. 1 2 3 Sensitive to cold
- 125. 1 2 3 Dry or scaly skin
- 126. 1 2 3 Temporary constipation
- 127. 1 2 3 Mental sluggishness
- 128. 1 2 3 Hair coarse, falls out
- 129. 1 2 3 Tension in head upon arising
wears off during day
- 130. 1 2 3 Slow pulse below 65
- 131. 1 2 3 Changing urinary function
- 132. 1 2 3 Sounds appear diminished
- 133. 1 2 3 Reduced initiative

____ _ TOTAL
1 2 3

GROUP 7C

- 134. 1 2 3 Failing memory with age
- 135. 1 2 3 Increased sex drive
- 136. 1 2 3 Episodes of tension in head
- 137. 1 2 3 Decreased sugar tolerance

____ _ TOTAL
1 2 3

GROUP 7D

- 138. 1 2 3 Abnormal thirst
- 139. 1 2 3 Bloating of abdomen
- 140. 1 2 3 Weight gain around hips or waist
- 141. 1 2 3 Sex drive reduced or lacking
- 142. 1 2 3 Tendency for stomach issues
- 143. 1 2 3 Immune system challenges
- 144. 1 2 3 Menstrual disorders

____ _ TOTAL
1 2 3

GROUP 7E

- 145. 1 2 3 Dizziness
- 146. 1 2 3 Headaches
- 147. 1 2 3 Hot flashes
- 148. 1 2 3 Hair growth on face
or body (female)
- 149. 1 2 3 Sugar in urine (not diabetes)
- 150. 1 2 3 Masculine tendencies (female)

____ _ TOTAL
1 2 3

GROUP 7F

- 151. 1 2 3 Weakness, dizziness
- 152. 1 2 3 Tired throughout day
- 153. 1 2 3 Nails weak, ridged
- 154. 1 2 3 Sensitive skin
- 155. 1 2 3 Stiff joints
- 156. 1 2 3 Perspiration increase
- 157. 1 2 3 Bowel discomfort
- 158. 1 2 3 Poor circulation
- 159. 1 2 3 Swollen ankles
- 160. 1 2 3 Crave salt
- 161. 1 2 3 Areas of skin darkening
- 162. 1 2 3 Upper respiratory sensitivity
- 163. 1 2 3 Tiredness
- 164. 1 2 3 Breathing challenges

____ _ TOTAL
1 2 3

GROUP 8

- 165. 1 2 3 Muscle weakness
- 166. 1 2 3 Lack of stamina
- 167. 1 2 3 Drowsiness after eating
- 168. 1 2 3 Muscular soreness
- 169. 1 2 3 Heart races
- 170. 1 2 3 Hyperirritable
- 171. 1 2 3 Feeling of a band around head
- 172. 1 2 3 Melancholia (feeling of sadness)
- 173. 1 2 3 Swelling of ankles
- 174. 1 2 3 Change in urinary function
- 175. 1 2 3 Tendency to consume
sweets/carbohydrates
- 176. 1 2 3 Muscle spasms
- 177. 1 2 3 Blurred vision
- 178. 1 2 3 Involuntary muscle action
- 179. 1 2 3 Numbness
- 180. 1 2 3 Night sweats
- 181. 1 2 3 Rapid digestion
- 182. 1 2 3 Sensitivity to noise
- 183. 1 2 3 Redness of palms of hands and
bottom of feet
- 184. 1 2 3 Visible veins on chest and abdomen
- 185. 1 2 3 Hemorrhoids
- 186. 1 2 3 Apprehension (feeling that
something bad is going to happen)

- 187. 1 2 3 Nervousness causing
loss of appetite
- 188. 1 2 3 Nervousness with indigestion
- 189. 1 2 3 Gastritis
- 190. 1 2 3 Forgetfulness
- 191. 1 2 3 Thinning hair

____ _ TOTAL
1 2 3

FEMALE ONLY

- 192. 1 2 3 Very easily fatigued
- 193. 1 2 3 Premenstrual tension
- 194. 1 2 3 Menses more painful than usual
- 195. 1 2 3 Depressed feelings
before menstruation
- 196. 1 2 3 Painful breasts during menses
- 197. 1 2 3 Menstruate too frequently
- 198. 1 2 3 Hysterectomy/ovaries removed
- 199. 1 2 3 Menopausal hot flashes
- 200. 1 2 3 Menses scanty or missed
- 201. 1 2 3 Acne, worse at menses

____ _ TOTAL
1 2 3

MALE ONLY

- 202. 1 2 3 Less involved in
exercise/social activities
- 203. 1 2 3 Difficult to postpone urination
- 204. 1 2 3 Weak urinary stream
- 205. 1 2 3 Feeling of "blues" or melancholy
- 206. 1 2 3 Feeling of incomplete
bowel evacuation
- 207. 1 2 3 Lack of energy
- 208. 1 2 3 Muscles in arms and legs seem
softer/smaller
- 209. 1 2 3 Tire too easily
- 210. 1 2 3 Avoid activity
- 211. 1 2 3 Leg nervousness at night
- 212. 1 2 3 Diminished sex drive

____ _ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

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

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion	Large Intestine (Palpate)	Adrenals	Pass/Fail Zinc Taste Test
_____ Hydrochloric	_____ Ascending	Pass/Fail Pupil Dilation Exam	Pass/Fail Cuff Test
_____ Acid Point	_____ Transverse	Postural Hypotension	_____ Cuff Pressure
_____ Enzyme Point	_____ Descending	_____ Supine	_____ pH of Saliva
_____ Murphy's Sign		_____ Standing	_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning 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 such as 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 second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. 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 intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

Health Questionnaire

Name _____ Gender _____ Date _____

Age _____ Age I feel _____ Weight _____ Optimum Weight _____

Last time that I felt really good _____

Anything happening before I started to feel bad? _____

(new medications, change in medications, physical trauma, emotional trauma etc.)

Main Symptom: _____

How long have you had it? _____

What makes it better? _____

What makes it worse? _____

Anything about your symptoms that don't make sense: _____

Any other symptoms associated with it or started at same time? _____

Hereditary History (circle)	You	Father Father's Family	Mother Mother's Family	Children	Sibling
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Neurological (Depression/ADHD/Memory/Anxiety)	Y	F	M	C	S
Digestion (Constipation/Diarrhea/Bloating/Heartburn)	Y	F	M	C	S
Heart Disease/Stroke/Blood Pressure	Y	F	M	C	S
Endocrine (Thyroid/adrenals/reproductive)	Y	F	M	C	S
Arthritis (Osteo/Rheumatoid/Gouty)	Y	F	M	C	S
Sugar (Hypoglycemia/Diabetes)	Y	F	M	C	S
Insomnia (Hard to get to sleep/stay asleep)	Y	F	M	C	S
Autoimmune (Lupus/Diabetes/Thyroid/Rheum)	Y	F	M	C	S
Cancer	Y	F	M	C	S

Anything else that you think is important for me to know??? _____

List of Medications (prescription and non-prescription)

Name	Purpose of Medication	Life sustaining?
1. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

Diet

1. How would you rate your diet for health (1-10) 10 being best _____
2. How many meals a day do you eat a day? _____
3. How many glasses of water do you drink a day? _____
4. How many times a week to you eat fast foods? _____
5. What percentage of foods that you eat are organic ? _____
6. Do you try to avoid refined foods, trans fats, artificial flavorings? _____
7. Are you addicted to sugar or caffeine? _____

Lifestyle

1. Exercise Type _____ How often? _____ Duration _____
2. Meditation? _____ How Often? _____
3. Yoga? _____ How Often? _____