

SYMPTOM SURVEY FORM

(Restricted to Professional Use)

PATIENT _____ CLINICIAN Eli Jacobe, Lic.Ac. DATE _____

INSTRUCTIONS: *Number the boxes which apply only to you. Use (1) if symptom occur once or twice a year, (2) if it occurs several times per year, and (3) if you are aware of it almost constantly.*

GROUP ONE

- | | | |
|---|--|--|
| 1 <input type="checkbox"/> Acid food upset | 8 <input type="checkbox"/> Gag easily | 15 <input type="checkbox"/> Appetite reduced |
| 2 <input type="checkbox"/> Get chilled, often | 9 <input type="checkbox"/> Unable to relax; startle easily | 16 <input type="checkbox"/> Cold sweats often |
| 3 <input type="checkbox"/> "Lump" in throat | 10 <input type="checkbox"/> Extremities cold, clammy | 17 <input type="checkbox"/> Fever easily raised |
| 4 <input type="checkbox"/> Dry Mouth-eyes-nose | 11 <input type="checkbox"/> Strong light irritates | 18 <input type="checkbox"/> Neuralgia like pains. |
| 5 <input type="checkbox"/> Pulse speeds up after meal | 12 <input type="checkbox"/> Urine amount reduced | 19 <input type="checkbox"/> Staring, blinks little |
| 6 <input type="checkbox"/> Keyed up - fail to calm | 13 <input type="checkbox"/> Heart pounds after retiring | 20 <input type="checkbox"/> Sour stomach frequent |
| 7 <input type="checkbox"/> Cuts heal slowly | 14 <input type="checkbox"/> "Nervous" stomach | |

GROUP TWO

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

GROUP THREE

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

GROUP FOUR

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

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Group Five

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

Group Six

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

(A)

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerant 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)

- 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 the day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

Group Seven

(C)

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

(D)

- 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)

- 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)

- 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 Allergy - tendency to asthma
- 170 Weakness after cold, flu
- 171 Exhaustion - muscular and nervous
- 172 Respiratory disorders

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Female Only	Male Only
<p>173 <input type="checkbox"/> Very easily fatigued</p> <p>174 <input type="checkbox"/> Premenstrual tension</p> <p>175 <input type="checkbox"/> Painful menses</p> <p>176 <input type="checkbox"/> Depressed feelings before menstruation</p> <p>177 <input type="checkbox"/> Menstruation excessive and prolonged</p> <p>178 <input type="checkbox"/> Painful breasts</p> <p>179 <input type="checkbox"/> Menstruated too frequently</p> <p>180 <input type="checkbox"/> Vaginal discharge</p>	<p>181 <input type="checkbox"/> Hysterectomy/ovaries removed</p> <p>182 <input type="checkbox"/> Menopausal hot flashes</p> <p>183 <input type="checkbox"/> Menses scanty or missed</p> <p>184 <input type="checkbox"/> Acne, worse at menses</p> <p>185 <input type="checkbox"/> Depression of long standing</p> <p>186 <input type="checkbox"/> Prostate trouble</p> <p>187 <input type="checkbox"/> Urination difficult or dribbling</p> <p>188 <input type="checkbox"/> Night urination frequent</p> <p>189 <input type="checkbox"/> Depression</p> <p>190 <input type="checkbox"/> Pain on inside of legs or heels</p> <p>191 <input type="checkbox"/> Feeling of incomplete bowel evacuation</p> <p>192 <input type="checkbox"/> Lack of energy</p> <p>193 <input type="checkbox"/> Migrating aches and pains</p> <p>194 <input type="checkbox"/> Tire too easily</p> <p>195 <input type="checkbox"/> Avoids activity</p> <p>196 <input type="checkbox"/> Leg nervousness at night</p> <p>197 <input type="checkbox"/> Diminished sex drive</p>
IMPORTANT	
<p>TO THE PATIENT: Please list the five main physical complaints you have in order of importance.</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p>	

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin Percent _____ Glucose Percent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

RECOMMENDATIONS AND SUMMARY:

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____