

DIRECTIONS FOR THE SYMPTOM SURVEY FORM

1. After printing, fill in the date, your name, age, surgeries, medications and supplements.
2. Place an "X" in any and all of the boxes by the symptoms that you have on a daily/weekly basis only.
3. Complete the Barnes Thyroid Test at the bottom of the third page. (Even if you do or do not have a thyroid problem.
4. Write down everything you eat/drink for one week. List any symptoms you may have at the bottom.
5. Have your blood pressure taken sitting, then immediately standing. Record it.
6. Have your pulse taken sitting, then standing also. Record it.
7. Complete the Iodine Patch Test.
8. Print each form and fill out entirely:
9. After you have completed the above list, please return all completed forms to:

Drugless Healthcare Solutions
P. O. Box 136
Avon, OH 44011
or
Fax: 440-322-2502

NAME: _____ AGE: _____ DATE: _____

SURGERIES: _____

MEDICATIONS: _____

SUPPLEMENTS: _____

(If necessary, attach additional sheet.)

As a result of your consultation, would you prefer to have your personal evaluation report on a cassette or CD? (Circle One)

Instructions: Place an "X" by the symptoms that you notice on a daily or a constant basis.

GROUP ONE

- | | | |
|--|---|--|
| 1 <input type="checkbox"/> Acid foods 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; startles 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 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 craving for
sweets or snacks |
| 45 <input type="checkbox"/> Irritable before meals | 52 <input type="checkbox"/> Awaken after 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"/> Opens windows in closed room | 67 <input type="checkbox"/> Dull pain in chest or
radiating into left arm,
worse on exertion | 72 <input type="checkbox"/> Tension under the breastbone,
or feeling of "tightness",
worse on exertion |
| 61 <input type="checkbox"/> Susceptible to colds and fevers | | |
| 62 <input type="checkbox"/> Afternoon "yawner" | | |

GROUP FIVE

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

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 sensations, eating relieves | 103 <input type="checkbox"/> Indigestion ½ - 1 hour after eating; may be up to 3-4 hrs. | 106 <input type="checkbox"/> Stomach “bloating” after eating |

GROUP SEVEN

- | | | |
|---|--|---|
| (A) | (C) | (E) |
| 107 <input type="checkbox"/> Insomnia | 137 <input type="checkbox"/> Failing memory | 150 <input type="checkbox"/> Dizziness |
| 108 <input type="checkbox"/> Nervousness | 138 <input type="checkbox"/> Low blood pressure | 151 <input type="checkbox"/> Headaches |
| 109 <input type="checkbox"/> Can't gain weight | 139 <input type="checkbox"/> Increased sex drive | 152 <input type="checkbox"/> Hot flashes |
| 110 <input type="checkbox"/> Intolerance to heat | 140 <input type="checkbox"/> Headaches, “splitting or rending” type | 153 <input type="checkbox"/> Increased blood pressure |
| 111 <input type="checkbox"/> Highly emotional | 141 <input type="checkbox"/> Decreased sugar tolerance | 154 <input type="checkbox"/> Hair growth on face or body (female) |
| 112 <input type="checkbox"/> Flush easily | | 155 <input type="checkbox"/> Sugar in urine (not diabetes) |
| 113 <input type="checkbox"/> Night sweats | | 156 <input type="checkbox"/> Masculine tendencies (female) |
| 114 <input type="checkbox"/> Thin, moist skin | (D) | (F) |
| 115 <input type="checkbox"/> Inward trembling | 142 <input type="checkbox"/> Abnormal thirst | 157 <input type="checkbox"/> Weakness, dizziness |
| 116 <input type="checkbox"/> Heart palpitates | 143 <input type="checkbox"/> Bloating of abdomen | 158 <input type="checkbox"/> Chronic fatigue |
| 117 <input type="checkbox"/> Increased appetite without weight gain | 144 <input type="checkbox"/> Weight gain around hips or waist | 159 <input type="checkbox"/> Low blood pressure |
| 118 <input type="checkbox"/> Pulse fast at rest | 145 <input type="checkbox"/> Sex drive reduced or lacking | 160 <input type="checkbox"/> Nails weak, ridged |
| 119 <input type="checkbox"/> Eyelids and face twitch | 146 <input type="checkbox"/> Tendency to ulcers, colitis | 161 <input type="checkbox"/> Tendency to hives |
| 120 <input type="checkbox"/> Irritable and restless | 147 <input type="checkbox"/> Increased sugar tolerance | 162 <input type="checkbox"/> Arthritic tendencies |
| 121 <input type="checkbox"/> Can't work under pressure | 148 <input type="checkbox"/> Women: menstrual disorders | 163 <input type="checkbox"/> Perspiration increase |
| (B) | 149 <input type="checkbox"/> Young girls: lack of menstrual function | 164 <input type="checkbox"/> Bowel disorders |
| 122 <input type="checkbox"/> Increase in weight | | 165 <input type="checkbox"/> Poor circulation |
| 123 <input type="checkbox"/> Decrease in appetite | | 166 <input type="checkbox"/> Swollen ankles |
| 124 <input type="checkbox"/> Fatigue easily | | 167 <input type="checkbox"/> Crave salt |
| 125 <input type="checkbox"/> Ringing in ears | | 168 <input type="checkbox"/> Brown spots or bronzing of skin |
| 126 <input type="checkbox"/> Sleepy during day | | 169 <input type="checkbox"/> Allergies – tendency to asthma |
| 127 <input type="checkbox"/> Sensitive to cold | | 170 <input type="checkbox"/> Weakness after colds, influenza |
| 128 <input type="checkbox"/> Dry or scaly skin | | 171 <input type="checkbox"/> Exhaustion – muscular and nervous |
| 129 <input type="checkbox"/> Constipation | | 172 <input type="checkbox"/> Respiratory disorders |
| 130 <input type="checkbox"/> Mental sluggishness | | |
| 131 <input type="checkbox"/> Hair coarse, falls out | | |
| 132 <input type="checkbox"/> Headaches upon arising wear off during day | | |
| 133 <input type="checkbox"/> Slow pulse, below 65 | | |
| 134 <input type="checkbox"/> Frequency of urination | | |
| 135 <input type="checkbox"/> Impaired hearing | | |
| 136 <input type="checkbox"/> Reduced initiative | | |

GROUP EIGHT

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Apprehension | <input type="checkbox"/> Noise sensitivity | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Acoustic hallucinations | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Morbid fears | <input type="checkbox"/> Tendency to cry without reason | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Hypochondria | <input type="checkbox"/> Feeling something dreadful | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Forgetfulness | will happen | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Weakness | <input type="checkbox"/> Distraction |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Craving for sweets | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Muscular soreness | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Instability |
| <input type="checkbox"/> Depression | | |

FEMALE ONLY

- | | |
|---|---|
| 173 <input type="checkbox"/> Very easily fatigued | 179 <input type="checkbox"/> Menstruate too frequently |
| 174 <input type="checkbox"/> Premenstrual tension | 180 <input type="checkbox"/> Vaginal discharge |
| 175 <input type="checkbox"/> Painful menses | 181 <input type="checkbox"/> Hysterectomy/ovaries removed |
| 176 <input type="checkbox"/> Depressed feelings before menstruation | 182 <input type="checkbox"/> Menopausal hot flashes |
| 177 <input type="checkbox"/> Menstruation excessive and prolonged | 183 <input type="checkbox"/> Menses scanty or missed |
| 178 <input type="checkbox"/> Painful breasts | 184 <input type="checkbox"/> Acne, worse at menses |
| | 185 <input type="checkbox"/> Depression of long standing |

MALE ONLY

- | |
|---|
| 186 <input type="checkbox"/> Prostate trouble |
| 187 <input type="checkbox"/> Urination difficult or dribbling |
| 188 <input type="checkbox"/> Night urination frequent |
| 189 <input type="checkbox"/> Depression |
| 190 <input type="checkbox"/> Pain on inside of legs or heels |
| 191 <input type="checkbox"/> Feeling of incomplete bowel evacuation |
| 192 <input type="checkbox"/> Lack of energy |
| 193 <input type="checkbox"/> Migrating aches and pains |
| 194 <input type="checkbox"/> Tire too easily |
| 195 <input type="checkbox"/> Avoids activity |
| 196 <input type="checkbox"/> Leg nervousness at night |
| 197 <input type="checkbox"/> Diminished sex drive |

THYROID PATCH TEST

Purchase a small bottle of Tincture of Iodine and paint a 2" x 2" patch at the crease of your elbow or behind your knee. The iodine patch should be seen for 24 hours. If the iodine patch leaves, it is a sign that your body is utilizing and/or absorbing the iodine. Keep track of the hours that the iodine is visible.

_____ Hours

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: _____

BP SIT _____

BP STAND _____

PULSE SIT _____

PULSE STAND _____

SALIVA PH _____

BLOOD TYPE _____

Patient's Daily Diet Report

Patient's Name: _____ Dates: From _____ To _____

(Be sure to list all foods and beverages consumed each day of this Diet Report.)

	1 st Day	2 nd Day	3 rd Day	4 th Day	5 th Day	6 th Day	7 th Day
Morning Meal							
Noon Meal							
Evening Meal							
Foods And Beverages Used at Other Times							
SYMPTOMS							