

Your Bridge to Health The Scientific Alternative

PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____

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

Primary Complaints

- | | | |
|---|---|---|
| <p>090 <input type="checkbox"/> General Good Health</p> <p>091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis</p> <p>001 <input type="checkbox"/> Skin Disorder L25.9</p> <p>002 <input type="checkbox"/> Acne L70.8</p> <p>003 <input type="checkbox"/> Psoriasis L40.8</p> <p>004 <input type="checkbox"/> Urticaria (Hives) L50.9</p> <p>005 <input type="checkbox"/> ADD/ADHD F90.1/F90.9</p> <p>006 <input type="checkbox"/> Allergies, Unspecified J30.9</p> <p>007 <input type="checkbox"/> Allergic Rhinitis from food J30.5</p> <p>008 <input type="checkbox"/> Sinusitis J01.90</p> <p>009 <input type="checkbox"/> Alzheimer's G30.9</p> <p>010 <input type="checkbox"/> Poor Concentration/Memory F07.8</p> <p>011 <input type="checkbox"/> Parkinson's Disease G20</p> <p>012 <input type="checkbox"/> Anemia D64.9</p> <p>013 <input type="checkbox"/> Arthritic Disorder M12.9</p> <p>014 <input type="checkbox"/> Osteoporosis M81.0</p> <p>015 <input type="checkbox"/> Asthma J45.909</p> <p>016 <input type="checkbox"/> Emphysema J43.9</p> <p>017 <input type="checkbox"/> Cancer</p> <p style="padding-left: 20px;">018 <input type="checkbox"/> Breast C50.919female C50.929male</p> <p style="padding-left: 20px;">019 <input type="checkbox"/> Prostate C61</p> <p style="padding-left: 20px;">020 <input type="checkbox"/> Lung C34.90</p> <p style="padding-left: 20px;">021 <input type="checkbox"/> Colon and Rectal C18.9</p> <p style="padding-left: 20px;">022 <input type="checkbox"/> Skin C44.90</p> <p style="padding-left: 20px;">023 <input type="checkbox"/> Leukemia w/o remission C95.90
Leukemia w/ remission C95.91</p> <p style="padding-left: 20px;">024 <input type="checkbox"/> Lymphoma, malignant C85.89</p> <p style="padding-left: 20px;">025 <input type="checkbox"/> Brain Tumor, malignant C71.9</p> <p>027 <input type="checkbox"/> Anxiety Disorder F41.9</p> <p>028 <input type="checkbox"/> Autism F84.0</p> <p>033 <input type="checkbox"/> Edema R60.9</p> <p>034 <input type="checkbox"/> Eczema L25.9</p> <p>035 <input type="checkbox"/> Chronic Fatigue R53.82</p> <p>036 <input type="checkbox"/> Circulatory Disorder I99.9</p> <p>037 <input type="checkbox"/> Heart Disease I51.9</p> <p>038 <input type="checkbox"/> High Cholesterol E78.0</p> | <p>039 <input type="checkbox"/> High Blood Pressure I10</p> <p>040 <input type="checkbox"/> Low Blood Pressure I95.9</p> <p>041 <input type="checkbox"/> Tachycardia
(High Heart Rate) R00.0</p> <p>042 <input type="checkbox"/> Numbness R20.9</p> <p>043 <input type="checkbox"/> Constipation K59.00</p> <p>044 <input type="checkbox"/> Indigestion K30</p> <p>045 <input type="checkbox"/> Ulcerative Colitis K51.90</p> <p>046 <input type="checkbox"/> Depression F32.9</p> <p>047 <input type="checkbox"/> Diabetes Mellitus E11.9</p> <p>030 <input type="checkbox"/> Diabetes Type I E10.9</p> <p>031 <input type="checkbox"/> Diabetes Type II E11.65</p> <p>029 <input type="checkbox"/> Hyperglycemia
[high blood sugar] R73.09</p> <p>048 <input type="checkbox"/> Hypoglycemia
[low blood sugar] E16.2</p> <p>049 <input type="checkbox"/> Dizziness/Balance Problem
R42</p> <p>050 <input type="checkbox"/> Ear Infection H65.90</p> <p>051 <input type="checkbox"/> Epstein Barr B27.90</p> <p>052 <input type="checkbox"/> Eye Problems H57.13</p> <p>053 <input type="checkbox"/> Cataracts H26.9</p> <p>054 <input type="checkbox"/> Glaucoma H40.9</p> <p>055 <input type="checkbox"/> Macular Degeneration H35.30</p> <p>056 <input type="checkbox"/> Fever R50.9</p> <p>057 <input type="checkbox"/> Fibromyalgia M79.7</p> <p>058 <input type="checkbox"/> Gallbladder Disorder K82.9</p> <p>059 <input type="checkbox"/> Gout M10.9</p> <p>060 <input type="checkbox"/> Headaches R51</p> <p>061 <input type="checkbox"/> Hearing Loss H91.90</p> <p>062 <input type="checkbox"/> Infertility, male N46.9</p> <p>064 <input type="checkbox"/> Liver Disease K76.9</p> <p style="padding-left: 20px;">065 <input type="checkbox"/> Hepatitis K71.6</p> <p style="padding-left: 20px;">066 <input type="checkbox"/> Hepatitis B B16.9</p> <p style="padding-left: 20px;">067 <input type="checkbox"/> Hepatitis C B17.10</p> <p>068 <input type="checkbox"/> Kidney Disorder N28.9 or
Bladder Disorder N32.9</p> | <p>063 <input type="checkbox"/> Prostate Disorder N42.9</p> <p>069 <input type="checkbox"/> Hyperthyroidism E05.90</p> <p>070 <input type="checkbox"/> Hypothyroidism E03.9</p> <p>071 <input type="checkbox"/> Systemic Lupus M32.10</p> <p>072 <input type="checkbox"/> Infertility, female M97.9</p> <p>073 <input type="checkbox"/> Interstitial Cystitis N30.11</p> <p>074 <input type="checkbox"/> Irregular Menstrual Cycle N92.6</p> <p>075 <input type="checkbox"/> Menopausal Symptoms N95.1</p> <p>076 <input type="checkbox"/> Hot Flashes N95.1</p> <p>077 <input type="checkbox"/> Mental Disorder F99</p> <p>078 <input type="checkbox"/> Insomnia G47.00</p> <p>079 <input type="checkbox"/> Mouth/Throat/Tongue</p> <p>080 <input type="checkbox"/> Canker Sores K12.0</p> <p>081 <input type="checkbox"/> Overweight E66.3</p> <p>082 <input type="checkbox"/> Underweight R63.6</p> <p>083 <input type="checkbox"/> Sexual Disorder F66</p> <p>084 <input type="checkbox"/> Spinal Problems M53.9</p> <p>085 <input type="checkbox"/> Obesity E66.9</p> <p>086 <input type="checkbox"/> GERD K21.9</p> <p>087 <input type="checkbox"/> HIV B20</p> <p>088 <input type="checkbox"/> Crohn's Disease K50.90</p> <p>089 <input type="checkbox"/> Irritable Bowel Syndrome K58.9</p> <p>092 <input type="checkbox"/> Normal Pregnancy Z33.1
<i>**only applicable if currently pregnant</i></p> <p>093 <input type="checkbox"/> Shingles B02.9</p> <p>140 <input type="checkbox"/> Migraines G43.909</p> <p>141 <input type="checkbox"/> Rheumatoid Arthritis M06.9</p> <p>142 <input type="checkbox"/> Non-Systemic Lupus L93.0</p> <p>143 <input type="checkbox"/> Multiple Sclerosis G35</p> <p>144 <input type="checkbox"/> ALS (Lou Gehrig's) G12.21</p> <p>145 <input type="checkbox"/> Polymyalgia Rheumatica M35.3</p> <p>146 <input type="checkbox"/> Scleroderma M34.9</p> <p>171 <input type="checkbox"/> Goiter E04.9</p> <p>178 <input type="checkbox"/> Raynaud's Syndrome I73.00</p> <p>179 <input type="checkbox"/> Hemochromatosis E83.119</p> <p>180 <input type="checkbox"/> Thalassemia D56.8</p> |
|---|---|---|

If necessary, please state your most significant concern...

General Health

- 100 Fingernail base is pink
 - 101 Fingernail base is purple
 - 102 Fingernails have ridges or white spots
 - 103 Fingernails are soft
 - 104 Fingernails are splitting
 - 105 Fingernails peel
 - 106 Pale fingernail beds
 - 107 Blacks out easily
 - 108 Balance problems
 - 109 Difficulty walking
 - 110 Has tattoos
 - 111 Brittle hair
 - 112 Dry hair
 - 113 Thin hair
 - 114 Hair loss
 - 115 Drinks alcoholic beverages daily
 - 116 Drinks less than 8 glasses of water per day
 - 117 Currently on Chemotherapy
 - 118 Currently on radiation treatment
 - 119 Had chemotherapy in the past
 - 120 Has had radiation treatments in the past
 - 121 Gained over 20 lbs in the last 12 months
 - 122 Somewhat Overweight
 - 123 Somewhat Underweight
 - 124 Unexplained loss of >20lbs in last 4 months
 - 125 Energy level is worse than it was 5 years ago
 - 127 Sleeps less than 6 hours per night
 - 128 Unable to recall dreams the next day
 - 129 Sensitive to chemicals, paint, fumes, cologne
 - 130 Had blood transfusion in the past
 - 131 Had transplant in the past
 - 138 Takes anti-rejection drugs
 - 132 Had a major accident or injury
 - 137 Sleep Apnea
 - 139 Toxic chemical exposure
 - 175 Has been out of the country recently
 - 176 Had childhood vaccines
 - 177 Had a vaccine in the last 12 months
 - 147 Had a flu shot last year
 - 182 Had a pneumonia vaccine last year
 - 183 Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184 Cancer
 - 185 Heart Disease
 - 186 Diabetes
 - 187 Alcoholism
 - 188 Depression
 - 189 Obesity

Lifestyle & Environment

Do you use? Well Water City Water Filtered? Yes No Filter Type? _____

What kind of pipes are in your home? Steel CPVC Copper Pex Other _____

What year was your home built? _____ Any renovations in the past year? _____

Do you use chlorine bleach or other heavy duty cleaners in your home/work? Yes No

Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? Yes No

Explain: _____

Have you ever worked around industrial solvents, chemicals or pesticides? Yes No

Explain: _____

- 380 Drinks beverages from a can
- 370 Drinks alcohol
- 371 Drinks caffeinated coffee
- 372 Drinks caffeinated pop/soda
- 373 Drinks caffeinated tea
- 374 Drinks decaffeinated coffee
- 375 Drinks decaffeinated pop/soda
- 376 Drinks decaffeinated tea
- 377 Drinks >3 cups of coffee daily
- 378 Drinks >3 cups of tea per day
- 388 Drinks diet pop/soda
- 379 Drinks >1 pop/sodas per day
- I had 4 alcoholic drinks in one day:
 - 172 never
 - 173 more than 3 months ago
 - 174 less than 3 months ago
- 381 Has >5 alcoholic drinks/week
- 391 Craves sugar / starches
- 382 Currently smokes
- 383 Quit smoking in last 5 years
- 384 Smoked for >5 years
- 385 Smokes >1 pack per day
- 126 Rarely exercises
- 133 Regularly exercises
- 386 Takes Vitamins
- 134 Vegetarian
- 135 Eats no red meat
- 136 Eats no meat, no dairy
- 387 Frequent use of artificial sweeteners
- 389 Anorexia

390 Bulimic

Surgeries

- 700 Tonsillectomy and/or Adenoids
- 701 Appendix
- 702 Gallbladder
- 703 Thyroid
- 704 Hysterectomy, complete
- 705 Hysterectomy, partial
- 706 Tubal ligation

- 707 Breast implants
- 708 Cancer
- 709 Coronary by-pass
- 710 Spinal surgery
- 711 Extremity surgery
- 712 Hip replacement
- 713 Knee replacement

- 714 Splenectomy
 - 715 Radiated thyroid
 - 716 Cataract surgery
 - 717 Hemorrhoidectomy
 - 718 Bariatric/Weight loss
- Type: _____

Gastrointestinal

- 265 4-5 bowel movements per week
- 266 3 or less bowel movements per week
- 267 6 or more bowel movements per week
- 268 Black tarry stools
- 269 Pale or yellow colored stool
- 270 Blood stools
- 271 Constipation
- 272 Hemorrhoids
- 273 Loose bowel movements
- 274 Frequent diarrhea
- 275 Frequent nausea
- 276 Frequent vomiting
- 277 Abdominal gas
- 278 Belching and burping after eating
- 279 Bloating after eating
- 280 Severe abdominal pains
- 281 Stomach ulcers
- 282 Uses digestive aids
- 283 Uses laxatives

- 284 Immediate indigestion upon eating
- 285 Indigestion in 2 hours or more after meals
- 286 Indigestion within 1 hour after meals
- 287 Difficulty swallowing
- 288 Eating relieves fatigue
- 289 Eats when nervous
- 290 Excessive hunger
- 291 Poor appetite
- 292 Experiences fainting spells when hungry
- 293 Feels shaky when hungry
- 294 Frequently drowsy after eating a meal
- 295 Gall bladder disease
- 296 Has had intestinal worms
- 297 Reflux/Hiatal hernia
- 298 Liver disease
- 299 Irritable Bowel Syndrome
- 300 Diverticulitis
- 301 Diverticulosis

Respiratory

- 485 Catches severe colds
- 486 Chronic chest condition
- 487 Chronic cough
- 488 Constant runny nose
- 489 COPD
- 490 Difficulty breathing

- 491 Frequent colds
- 492 Frequent nose bleeds
- 493 Frequent sinus infections
- 494 Frequent stuffy nose
- 495 Hay fever
- 496 Nasal polyps

- 497 Night sweats
- 498 Post nasal drip
- 499 Sneezing spells
- 500 Spits up blood
- 501 Spits up phlegm
- 502 Wheezes

Mouth and Throat

- 400 Bad breath
- 401 Bitter taste in the mouth
in the morning
- 402 Dry mouth
- 403 Excessive saliva
- 404 Sores or cracks in the
corners of the mouth
- 405 Glands often swell
- 406 Frequent canker sores

- 407 Frequent fever blisters
- 408 Frequent sore throats
- 409 Frequently has a sore
tongue
- 410 Sore gums
- 411 Swollen gums
- 412 Swollen tongue
- 413 Tongue burns

- 414 Tongue has grooves or fissures
- 415 Tongue is coated
- 416 Gums bleed when brushing teeth
- 417 Toothaches
- 418 Amalgam dental fillings
- 420 Other dental fillings
(gold, composite, etc)
- 419 Has had root canal(s)

Endocrine

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

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
205 Heart palpitations

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
530 Skin is rough, especially on the back of the arms
529 Skin eruptions
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
225 Tinnitus

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 others 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
- 639 Endometriosis
- 640 Breast reduction
- 641 Breast augmentation
- 642 Abortion
- 643 D&C
- 644 Tubal pregnancy
- 645 Uterine fibroids
- 646 Ovarian fibroids
- 647 Breast fibroids
- 648 Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

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

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

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

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

<input type="checkbox"/> Dairy	<input type="checkbox"/> Gluten	<input type="checkbox"/> Ragweed	<input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> Eggs	<input type="checkbox"/> Mold	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Tree nuts
<input type="checkbox"/> Garlic	<input type="checkbox"/> Peanut	<input type="checkbox"/> Soy	<input type="checkbox"/> Wheat
<input type="checkbox"/> Other _____			

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

<u>VITAMIN</u>	<u>BRAND</u>	<u>DOSAGE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____