

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Vegetarian: Yes No

INSTRUCTIONS: Number only the boxes which apply to you. Leave blank if you don't have the problem.

* Write 1 in the box for MILD symptoms (occur once or twice a year).

* Write 2 in the box for MODERATE symptoms (occur several times a month).

* Write 3 in the box for SEVERE symptoms (you are aware of it almost constantly).

Please do not use checkmarks in the boxes - fill in the boxes with a number or leave blank!

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 often |
| 7 <input type="checkbox"/> Cut heals slowly | 14 <input type="checkbox"/> "Nervous" stomach | |

GROUP TWO

- | | | |
|--|--|--|
| 21 <input type="checkbox"/> Joint stiffness on 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 rooms | 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" | | |

SYMPTOM SURVEY FORM - PAGE 2

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"/> Crave 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 sensations, eating relieves | 103 <input type="checkbox"/> Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs. | 106 <input type="checkbox"/> Stomach "bloating" after eating |

GROUP SEVEN

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

SYMPTOM SURVEY FORM - PAGE 3

GROUP EIGHT

- 198 Apprehension
- 199 Irritability
- 200 Morbid fears
- 201 Never seems to get well
- 202 Forgetfulness
- 203 Indigestion
- 204 Poor appetite
- 205 Craving for sweets
- 206 Muscular soreness
- 207 Depression; feelings of dread

- 208 Noise sensitivity
- 209 Accoustic hallucinations
- 210 Tendency to cry without reason
- 211 Hair is coarse and/or thinning
- 212 Weakness
- 213 Fatigue
- 214 Skin sensitive to touch
- 215 Tendency toward hives
- 216 Nervousness
- 217 Headache

- 218 Insomnia
- 219 Anxiety
- 220 Anorexia
- 221 Inability to concentrate; confusion
- 222 Frequent stuffy nose; sinus infections
- 223 Allergy to some foods
- 224 Loose joints

FEMALE ONLY

- 173 Very easily fatigued
- 174 Premenstrual tension
- 175 Painful menses
- 176 Depressed feelings before menstruation
- 177 Menstruation excessive and prolonged
- 178 Painful breasts

- 179 Menstruate too frequently
- 180 Vaginal discharge
- 181 Hysterectomy/overies removed
- 182 Menopausal hot flashes
- 183 Menses scanty or missed
- 184 Acne, worse at menses
- 185 Depression of long standing

MALE ONLY

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

IMPORTANT

Please list the five main complaints you have in the order of their importance:

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

PLEASE FILL OUT ALL 4 SHEETS THEN MAIL OR FAX TO JOY'S OFFICE

Name _____ Date _____ Work Phone _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Weight _____ Height _____

Who cooks the food you eat?

Occupation _____

History of Illness and Treatment _____

Operations, Accidents or Injuries _____

PLEASE LIST ALL VITAMINS, HERBS, OR HOMEOPATHIC REMEDIES THAT YOU ARE CURRENTLY TAKING & THE AMOUNTS

