Five Point Chiropractic
1101 Chestnut Street • Coshocton, Ohio 43812 • (740) 622-3553 (p) • (740) 622-5270 (f)

CONFIDENTIAL PATIENT INFORMATION

DATE

First Name MI Last Name Chief Complaint

Address Home Phone

City State ZIP Cell Phone

SS# Email

Date of Birth Marital Status M S W D

Occupation Employer

Address of Insured (if different than above)

Are your present systems or condition related to or the result of an auto collision, work-related injury or other personal injury (and therefore, someone else might be responsible for payment)? Yes No

Insurance Company Company's Phone Number

ID# Group #

Name of Policy Holder

Policy Holder's Date of Birth Policy Holder's Employer

Family Physician May we send your health information to this provider? Yes No

Emergency Contact (name and phone)

Have you had any spinal X-rays / MRIs / CTs taken in the last year? Yes No If yes, where?

Referred by

Do you have a pacemaker? Yes No Have you ever had hip or knee replacements? Yes No

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Five Point Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian Date

Five Point Chiropractic
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Patient name _____ Date _____

TERMS OF ACCEPTANCE

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the information below, and if you have any questions, feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service: Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Five Point Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

WOMEN ONLY: To the best of my knowledge,
I am / am NOT pregnant and give my permission / do NOT give my permission to X-ray me for diagnostic interpretation.
Circle one *Circle one*

MISSED APPOINTMENTS

A fee may be charged for all missed appointments that are not canceled prior to the scheduled visit.

CONSENT TO EVALUATE AND TREAT A MINOR

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

COMMUNICATIONS

In the event that we would need to communicate your health information, to whom may we do so?
Spouse _____

Children _____

Others _____

No one

May we leave messages regarding your personal healthcare information on any answering device, i.e., home answering machines or voice mails? Yes No

ACKNOWLEDGMENT

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print name _____

Signature _____ Date _____

PATIENT INTAKE FORM

Name _____ Date _____ Chart # _____

How often do you experience your symptoms? Circle frequency for each area.

Neck	Constant 75–100%	Frequent 50–75%	Occasional 25–50%	Intermittent >25%
Mid-back	Constant 75–100%	Frequent 50–75%	Occasional 25–50%	Intermittent >25%
Low back	Constant 75–100%	Frequent 50–75%	Occasional 25–50%	Intermittent >25%
_____	Constant 75–100%	Frequent 50–75%	Occasional 25–50%	Intermittent >25%
_____	Constant 75–100%	Frequent 50–75%	Occasional 25–50%	Intermittent >25%

Using a scale from 1 to 10 (10 being the worst), rate your problem in each area. Then describe your pain for each area (sharp, dull, achy, burning, stiff, tingly, etc.).

Neck	1	2	3	4	5	6	7	8	9	10	_____
Mid-back	1	2	3	4	5	6	7	8	9	10	_____
Low back	1	2	3	4	5	6	7	8	9	10	_____
_____	1	2	3	4	5	6	7	8	9	10	_____
_____	1	2	3	4	5	6	7	8	9	10	_____

How are your symptoms changing with time? Getting worse Not changing Getting better

How much has the problem interfered with your work?
Not at all Slightly Moderately Substantially Extremely

How much has the problem interfered with your social activities?
Not at all Slightly Moderately Substantially Extremely

What other health care provider, treatments or results have you had for this problem?

_____

_____

How long have you had this problem? _____

How do you think your problem began? _____

Do you consider this problem to be severe? Yes Yes, at times No

What aggravates your problem? _____

What makes the pain better? _____

How would you rate your overall health? Excellent Very good Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Do you have difficulty falling asleep? Yes No Continuity disturbances? Yes No

Early awakenings? Yes No Daytime drowsiness? Yes No

PATIENT INTAKE FORM (Page 2)

Name _____ Date _____ Chart # _____

Please list IMMEDIATE family member(s) (mother, father, brother, sister, children) with any of the following:

Rheumatoid arthritis _____
Heart problems _____
Diabetes _____
Cancer _____
Gout _____
ALS _____

Place a check in the PAST column if you have had the condition in the past. If you presently have a condition, place a check in the PRESENT column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
❍	❍	Headaches	❍	❍	High blood pressure	❍	❍	Diabetes
❍	❍	Neck pain	❍	❍	Heart attack	❍	❍	Excessive thirst
❍	❍	Upper back pain	❍	❍	Chest pains	❍	❍	Frequent urination
❍	❍	Mid-back pain	❍	❍	Stroke	❍	❍	HIV/AIDS
❍	❍	Low back pain	❍	❍	Angina	❍	❍	Drug/alcohol dependence
❍	❍	Shoulder pain	❍	❍	Kidney stones	❍	❍	Allergies
❍	❍	Elbow/upper arm pain	❍	❍	Kidney disorder	❍	❍	Depression
❍	❍	Wrist pain	❍	❍	Bladder infection	❍	❍	Systemic lupus
❍	❍	Hand pain	❍	❍	Painful urination	❍	❍	Epilepsy
❍	❍	Hip pain	❍	❍	Loss of bladder control	❍	❍	Dermatitis/eczema/rash
❍	❍	Upper leg pain	❍	❍	Prostate problems	❍	❍	Smoke/tobacco
❍	❍	Knee pain	❍	❍	Abnormal weight gain/loss			How many daily?
❍	❍	Ankle/foot pain	❍	❍	Loss of appetite			_____
❍	❍	Jaw pain	❍	❍	Abdominal pain			
❍	❍	Joint pain/stiffness	❍	❍	Ulcer			**WOMEN ONLY**
❍	❍	Arthritis	❍	❍	Hepatitis	❍	❍	Birth control pills
❍	❍	Rheumatoid arthritis	❍	❍	Liver /gall bladder disorder	❍	❍	Hormonal replacement
❍	❍	Cancer	❍	❍	General fatigue	❍	❍	Pregnancy #
❍	❍	Tumor	❍	❍	Muscular incoordination			_____
❍	❍	Asthma	❍	❍	Visual disturbances			1st day of last cycle
❍	❍	Chronic sinusitis	❍	❍	Dizziness			_____
								Length of cycle
								_____

List all surgeries and hospitalizations _____

_____

_____

What activities do you do at work?

Sit	Most of the day	Half the day	A little of the day
Stand	Most of the day	Half the day	A little of the day
Computer work	Most of the day	Half the day	A little of the day
Drive	Most of the day	Half the day	A little of the day

What activities do you do outside of work? _____

_____

Patient Signature _____ Date _____

EHR CERTIFICATION INFORMATION

The U.S. government requires that we supply the following information about patients:

Name Date of Birth Chart #

PRESCRIBED MEDICATIONS AND VITAMINS

	medication	# of refills	quantity of pills	strength	dose form	M.D. instruction
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

❍ **I am NOT taking any prescribed medication.**

DRUG ALLERGIES

	medication (i.e., Penicillin)	symptom (i.e., headache)
1.		
2.		
3.		
4.		

❍ **I do NOT have any medicinal allergies.**

Smoking Status:

every day | some days | former smoker | never smoked

Ethnicity/Race:

Caucasian/White | Hispanic/Latino | Black/African American | other

Preferred language:

English | Spanish | German | other

If the government needs to contact you, how would you like to receive this **Confidential Communication**?

phone call phone number: _____

text message cell number: _____

email email address: _____

mail mailing address: _____

I have been diagnosed with

asthma | diabetes

OFFICE USE ONLY

Vitals

Blood Pressure _____ / _____ Height _____ Weight _____

Entered into EZ Notes by: _____

Date and time: _____

NECK DISABILITY INDEX

Patient Name _____ Date _____

Score _____ % score _____

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please mark in each section the **ONE BOX** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **MOST CLOSELY** describes your present situation.

Section 1 • PAIN INTENSITY

❍ I have no pain at the moment.
❍ The pain is very mild at the moment.
❍ The pain is moderate at the moment.
❍ The pain is fairly severe at the moment.
❍ The pain is very severe at the moment.
❍ The pain is the worst imaginable at the moment.

Section 2 • PERSONAL CARE

❍ I can look after myself normally without causing extra pain.
❍ I can look after myself normally, but it causes extra pain.
❍ It is painful to look after myself, and I am slow and careful.
❍ I need some help but manage most of my personal care.
❍ I need help every day in most aspects of self-care.
❍ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 • LIFTING

❍ I can lift heavy weights without causing extra pain.
❍ I can lift heavy weights, but it gives me extra pain.
❍ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, i.e., on a table.
❍ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
❍ I can lift only very light weights.
❍ I cannot lift or carry anything at all.

Section 4 • WORK

❍ I can do as much work as I want.
❍ I can only do my usual work, but no more.
❍ I can do most of my usual work, but no more.
❍ I can't do my usual work.
❍ I can hardly do any work at all.
❍ I can't do any work at all.

Section 5 • HEADACHES

❍ I have no headaches at all.
❍ I have slight headaches that come infrequently.
❍ I have moderate headaches that come infrequently.
❍ I have moderate headaches that come frequently.
❍ I have severe headaches that come frequently.
❍ I have headaches almost all the time.

Section 6 • CONCENTRATION

❍ I can concentrate fully without difficulty.
❍ I can concentrate fully with slight difficulty.
❍ I have a fair degree of difficulty concentrating.
❍ I have a lot of difficulty concentrating.
❍ I have a great deal of difficulty concentrating.
❍ I can't concentrate at all.

Section 7 • SLEEP

❍ I have no trouble sleeping.
❍ My sleep is slightly disturbed for less than 1 hour.
❍ My sleep is mildly disturbed for up to 1–2 hours.
❍ My sleep is moderately disturbed for up to 2–3 hours.
❍ My sleep is greatly disturbed for up to 3–5 hours.
❍ My sleep is completely disturbed for up to 5–7 hours.

Section 8 • DRIVING

❍ I can drive my car without neck pain.
❍ I can drive as long as I want with slight neck pain.
❍ I can drive as long as I want with moderate neck pain.
❍ I can't drive as long as I want because of moderate neck pain.
❍ I can hardly drive at all because of severe neck pain.
❍ I can't drive at all because of neck pain.

Section 9 • READING

❍ I can read as much as I want with no neck pain.
❍ I can read as much as I want with slight neck pain.
❍ I can read as much as I want with moderate neck pain.
❍ I can't read as much as I want because of moderate neck pain.
❍ I can't read as much as I want because of severe neck pain.
❍ I can't read at all.

Section 10 • RECREATION

❍ I have no neck pain during all recreational activities.
❍ I have some neck pain with a few recreational activities.
❍ I have some neck pain with all recreational activities.
❍ I have neck pain with most recreational activities.
❍ I can hardly do recreational activities due to neck pain.
❍ I can't do any recreational activities due to neck pain.

REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Patient Name _____ Date _____

Score _____ % score _____ % disability _____

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by marking the **ONE CHOICE THAT MOST APPLIES TO YOU TODAY.**

Section 1 • PAIN INTENSITY

❍ The pain comes and goes and is very mild.
❍ The pain is mild and does not vary much.
❍ The pain comes and goes and is moderate.
❍ The pain is moderate and does not vary much.
❍ The pain comes and goes and is severe.
❍ The pain is severe and does not vary much.

Section 2 • PERSONAL CARE (washing, dressing, etc.)

❍ I do not have to change my way of washing or dressing in order to avoid pain.
❍ I do not normally change my way of washing or dressing even though it causes some pain.
❍ Washing and dressing increases the pain, but I manage not to change my way of doing it.
❍ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
❍ Because of the pain I am unable to do some washing and dressing without help.
❍ Because of the pain I am unable to do any washing and dressing without help.

Section 3 • LIFTING

❍ I can lift heavy weights without extra pain.
❍ I can lift heavy weights, but it causes extra pain.
❍ Pain prevents me from lifting heavy weights off the floor.
❍ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
❍ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
❍ I can lift only very light weights at the most.

Section 4 • WALKING

❍ I have no pain on walking.
❍ I have some pain on walking, but it does not increase with distance.
❍ I cannot walk more than 1 mile without increasing pain.
❍ I cannot walk more than ½ mile without increasing pain.
❍ I cannot walk more than ¼ mile without increasing pain.
❍ I cannot walk at all without increasing pain.

Section 5 • SITTING

❍ I can sit in any chair as long as I like.
❍ I can sit in my favorite chair as long as I like.
❍ Pain prevents me from sitting for more than 1 hour.
❍ Pain prevents me from sitting for more than ½ hour.
❍ Pain prevents me from sitting for more than 10 minutes.
❍ I avoid sitting because it increases pain immediately.

Section 6 • STANDING

❍ I can stand as long as I want without pain.
❍ I have some pain on standing but it doesn't increase with time.
❍ I cannot stand for longer than 1 hour without increasing pain.
❍ I cannot stand for longer than ½ hour without increasing pain.
❍ I cannot stand for longer than 10 minutes without increasing pain.
❍ I avoid standing because it increases the pain immediately.

Section 7 • SLEEPING

❍ I get no pain in bed.
❍ I get pain in bed but it does not prevent me from sleeping well.
❍ Because of pain my normal night's sleep is reduced by less than ¼.
❍ Because of pain my normal night's sleep is reduced by less than ½.
❍ Because of pain my normal night's sleep is reduced by less than ¾.
❍ Pain prevents me from sleeping at all.

Section 8 • SOCIAL LIFE

❍ My social life is normal and gives me no pain.
❍ My social life is normal but increases the degree of my pain.
❍ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
❍ Pain has restricted my social life, and I do not go out very often.
❍ Pain has restricted my social life to my home.
❍ I have hardly any social life because of the pain.

Section 9 • TRAVEL

❍ I get no pain while traveling.
❍ I get some pain while traveling, but none of my usual forms of travel make it any worse.
❍ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
❍ I get extra pain while traveling, which compels me to seek alternative forms of travel.
❍ Pain restricts all forms of travel.
❍ Pain prevents all forms of travel except that done lying down.

Section 10 • CHANGING DEGREE OF PAIN

❍ My pain is rapidly getting better.
❍ My pain fluctuates, but overall is definitely getting better.
❍ My pain seems to be getting better, but improvement is slow at present.
❍ My pain is neither getting better nor worse.
❍ My pain is gradually worsening.
❍ My pain is rapidly worsening.

SYSTEMS SURVEY FORM (restricted to professional use)

Patient Age Doctor Date

Circle the number that applies to you. If a symptom does not apply, leave it blank.
(**1**) for **MILD** symptoms (occurs rarely)
(**2**) for **MODERATE** symptoms (occurs several times a month)
(**3**) for **SEVERE** symptoms (occurs almost constantly)

GROUP ONE

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** Cuts heal slowly
8 • **1 2 3** Gag easily
9 • **1 2 3** Unable to relax, startles easily
10 • **1 2 3** Extremities cold, clammy
11 • **1 2 3** Strong light irritates
12 • **1 2 3** Urine amount reduced
13 • **1 2 3** Heart pounds after retiring
14 • **1 2 3** "Nervous" stomach
15 • **1 2 3** Appetite reduced
16 • **1 2 3** Cold sweats often
17 • **1 2 3** Fever easily raised
18 • **1 2 3** Neuralgia-like pains
19 • **1 2 3** Staring, blinks little
20 • **1 2 3** Sour stomach frequent

GROUP TWO

21 • **1 2 3** Joint stiffness after arising
22 • **1 2 3** Muscle/leg/toe cramps at night
23 • **1 2 3** "Butterfly" stomach, cramps
24 • **1 2 3** Eyes or nose watery
25 • **1 2 3** Eyes blink often
26 • **1 2 3** Eyelids swollen, puffy
27 • **1 2 3** Indigestion soon after meals
28 • **1 2 3** Always seem hungry, feels "lightheaded" often
29 • **1 2 3** Digestion rapid
30 • **1 2 3** Vomiting frequent
31 • **1 2 3** Hoarseness frequent
32 • **1 2 3** Breathing irregular
33 • **1 2 3** Pulse slow, feels "irregular"
34 • **1 2 3** Gagging reflex slow
35 • **1 2 3** Difficulty swallowing
36 • **1 2 3** Constipation, diarrhea alternating
37 • **1 2 3** "Slow starter"
38 • **1 2 3** Get "chilled" infrequently
39 • **1 2 3** Perspire easily
40 • **1 2 3** Circulation poor, sensitive to cold
41 • **1 2 3** Subject to colds, asthma, bronchitis

GROUP THREE

42 • **1 2 3** Eat when nervous
43 • **1 2 3** Excessive appetite
44 • **1 2 3** Hungry between meals
45 • **1 2 3** Irritable before meals
46 • **1 2 3** Get "shaky" if hungry
47 • **1 2 3** Fatigue, eating relieves
48 • **1 2 3** "Lightheaded" if meals delayed
49 • **1 2 3** Heart palpitates if meals missed or delayed
50 • **1 2 3** Afternoon headaches
51 • **1 2 3** Overeating sweets upsets
52 • **1 2 3** Awaken after few hours' sleep, hard to get back to sleep
53 • **1 2 3** Crave candy or coffee in afternoons
54 • **1 2 3** Moods of depression, "blues" or melancholy
55 • **1 2 3** Abnormal craving for sweets or snacks

GROUP FOUR

56 • **1 2 3** Hands and feet go to sleep easily, numbness
57 • **1 2 3** Sigh frequently, "air hunger"
58 • **1 2 3** Aware of "breathing heavily"
59 • **1 2 3** High altitude discomfort
60 • **1 2 3** Opens windows in closed room
61 • **1 2 3** Susceptible to colds and fevers
62 • **1 2 3** Afternoon "yawner"
63 • **1 2 3** Get "drowsy" often
64 • **1 2 3** Swollen ankles worse at night
65 • **1 2 3** Muscle cramps, worse during exercise; get "charley horses"
66 • **1 2 3** Shortness of breath on exertion
67 • **1 2 3** Dull pain in chest or radiating into left arm, worse on exertion
68 • **1 2 3** Bruise easily, "black and blue" spots
69 • **1 2 3** Tendency to anemia
70 • **1 2 3** "Nose bleeds" frequent
71 • **1 2 3** Noises in head, or "ringing in ears"
72 • **1 2 3** Tension under the breastbone, or feeling of "tightness," worse on exertion

SYSTEMS SURVEY FORM (Page 2)

GROUP FIVE

73 • 1 2 3 Dizziness
74 • 1 2 3 Dry skin
75 • 1 2 3 Burning feet
76 • 1 2 3 Blurred vision
77 • 1 2 3 Itching skin and feet
78 • 1 2 3 Excessive falling hair
79 • 1 2 3 Frequent skin rashes
80 • 1 2 3 Bitter, metallic taste in mouth in mornings
81 • 1 2 3 Bowel movements painful or difficult
82 • 1 2 3 Worrier, feels insecure
83 • 1 2 3 Feeling queasy; headache over eyes
84 • 1 2 3 Greasy foods upset
85 • 1 2 3 Stools light-colored
86 • 1 2 3 Skin peels on foot soles
87 • 1 2 3 Pain between shoulder blades
88 • 1 2 3 Use laxatives
89 • 1 2 3 Stools alternate from soft to watery
90 • 1 2 3 History of gallbladder attacks or gallstones
91 • 1 2 3 Sneezing attacks
92 • 1 2 3 Dreaming, nightmare-type bad dreams
93 • 1 2 3 Bad breath (halitosis)
94 • 1 2 3 Milk products cause distress
95 • 1 2 3 Sensitive to hot weather
96 • 1 2 3 Burning or itching anus
97 • 1 2 3 Crave sweets

GROUP SIX

98 • 1 2 3 Loss of taste for meat
99 • 1 2 3 Lower bowel gas several hours after eating
100 • 1 2 3 Burning stomach sensations, eating relieves
101 • 1 2 3 Coated tongue
102 • 1 2 3 Pass large amounts of foul-smelling gas
103 • 1 2 3 Indigestion ½–1 hour after eating; may be up to 3–4 hours after
104 • 1 2 3 Mucous colitis or "irritable bowel"
105 • 1 2 3 Gas shortly after eating
106 • 1 2 3 Stomach "bloating"

GROUP SEVEN

(A)

107 • 1 2 3 Insomnia
108 • 1 2 3 Nervousness
109 • 1 2 3 Can't gain weight
110 • 1 2 3 Intolerance to heat
111 • 1 2 3 Highly emotional
112 • 1 2 3 Flush easily
113 • 1 2 3 Night sweats
114 • 1 2 3 Thin, moist skin
115 • 1 2 3 Inward trembling
116 • 1 2 3 Heart palpitates
117 • 1 2 3 Increased appetite without weight gain
118 • 1 2 3 Pulse fast at rest
119 • 1 2 3 Eyelids and face twitch
120 • 1 2 3 Irritable and restless
121 • 1 2 3 Can't work under pressure

(B)

122 • 1 2 3 Increase in weight
123 • 1 2 3 Decrease in appetite
124 • 1 2 3 Fatigue easily
125 • 1 2 3 Ringing in ears
126 • 1 2 3 Sleepy during day
127 • 1 2 3 Sensitive to cold
128 • 1 2 3 Dry or scaly skin
129 • 1 2 3 Constipation
130 • 1 2 3 Mental sluggishness
131 • 1 2 3 Hair coarse, falls out
132 • 1 2 3 Headaches upon arising wear off during day
133 • 1 2 3 Slow pulse, below 65

(B continued)

134 • 1 2 3 Frequency of urination
135 • 1 2 3 Impaired hearing
136 • 1 2 3 Reduced initiative

(C)

137 • 1 2 3 Failing memory
138 • 1 2 3 Low blood pressure
139 • 1 2 3 Increased sex drive
140 • 1 2 3 Headaches, "splitting or rendering" type
141 • 1 2 3 Decreased sugar tolerance

(D)

142 • 1 2 3 Abnormal thirst
143 • 1 2 3 Bloating of abdomen
144 • 1 2 3 Weight gain around hips or waist
145 • 1 2 3 Sex drive reduced or lacking
146 • 1 2 3 Tendency to ulcers, colitis
147 • 1 2 3 Increased sugar tolerance
148 • 1 2 3 Women: menstrual disorders
149 • 1 2 3 Young girls: lack of menstrual function

(E)

150 • 1 2 3 Dizziness
151 • 1 2 3 Headaches
152 • 1 2 3 Hot flashes
153 • 1 2 3 Increased blood pressure
154 • 1 2 3 Hair growth on face or body (female)
155 • 1 2 3 Sugar in urine (not diabetes)
156 • 1 2 3 Masculine tendencies (female)

(F)

157 • 1 2 3 Weakness, dizziness
158 • 1 2 3 Chronic fatigue
159 • 1 2 3 Low blood pressure
160 • 1 2 3 Nails weak, ridged
161 • 1 2 3 Tendency to hives
162 • 1 2 3 Arthritic tendencies
163 • 1 2 3 Perspiration increase
164 • 1 2 3 Bowel disorders
165 • 1 2 3 Poor circulation
166 • 1 2 3 Swollen ankles
167 • 1 2 3 Crave salt
168 • 1 2 3 Brown spots or bronzing of skin
169 • 1 2 3 Allergies - tendency to asthma
170 • 1 2 3 Weakness after colds, influenza
171 • 1 2 3 Exhaustion - muscular and nervous
172 • 1 2 3 Respiratory disorders

SYSTEMS SURVEY FORM (Page 3)

GROUP EIGHT

173 • 1 2 3 Muscle weakness
174 • 1 2 3 Lack of stamina
175 • 1 2 3 Drowsiness after eating
176 • 1 2 3 Muscular soreness
177 • 1 2 3 Rapid heartbeat
178 • 1 2 3 Hyper-irritable
179 • 1 2 3 Feeling of a band around head
180 • 1 2 3 Melancholia (feeling of sadness)
181 • 1 2 3 Swelling of ankles
182 • 1 2 3 Diminished urination
183 • 1 2 3 Tendency to consume sweets or carbohydrates
184 • 1 2 3 Muscle spasms
185 • 1 2 3 Blurred vision
186 • 1 2 3 Loss of muscular control
187 • 1 2 3 Numbness
188 • 1 2 3 Night sweats
189 • 1 2 3 Rapid digestion
190 • 1 2 3 Sensitivity to noise
191 • 1 2 3 Redness of palms of hands and bottom of feet
192 • 1 2 3 Visible veins on chest and abdomen
193 • 1 2 3 Hemorrhoids
194 • 1 2 3 Apprehension (feeling that something bad is going to happen)
195 • 1 2 3 Nervousness causing loss of appetite
196 • 1 2 3 Nervousness with indigestion
197 • 1 2 3 Gastritis
198 • 1 2 3 Forgetfulness
199 • 1 2 3 Thinning hair

FEMALE ONLY

200 • 1 2 3 Very easily fatigued
201 • 1 2 3 Premenstrual tension
202 • 1 2 3 Painful menses
203 • 1 2 3 Depressed feelings before menstruation
204 • 1 2 3 Menstruation excessive and prolonged
205 • 1 2 3 Painful breasts
206 • 1 2 3 Menstruate too frequently
207 • 1 2 3 Vaginal discharge
208 • 1 2 3 Hysterectomy/ovaries removed
209 • 1 2 3 Menopausal hot flashes
210 • 1 2 3 Menses scanty or missed
211 • 1 2 3 Acne, worse at menses
212 • 1 2 3 Depression of long standing

MALE ONLY

213 • 1 2 3 Prostate trouble
214 • 1 2 3 Urination difficult or dribbling
215 • 1 2 3 Night urination frequent
216 • 1 2 3 Depression
217 • 1 2 3 Pain on inside of legs or heels
218 • 1 2 3 Feeling of incomplete bowel evacuation
219 • 1 2 3 Lack of energy
220 • 1 2 3 Migrating aches and pains
221 • 1 2 3 Tire too easily
222 • 1 2 3 Avoids activity
223 • 1 2 3 Leg nervousness at night
224 • 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. _____

2. _____

3. _____

4. _____

5. _____

TO BE COMPLETED BY DOCTOR

Postural Blood Pressure: Recumbent Standing Pulse

Hema-Combistix Urine readings: pH Albumin per cent Glucose per cent

Occult Blood pH Saliva pH Stool specimen Weight

Hemoglobin Blood Clotting Time

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	FEMALES HAVING MENSTRUAL CYCLES	MALES
Any two days during the month	The 2nd and 3rd day of flow OR any 5 days in a row	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. If 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:**

Date: **Temperature:**

Date: **Temperature:**