DELRAN CHIROPRACTIC ,PA

3001Bridgeboro rd
Delran ,NJ 08075
856-461-6262

PATIENT SYMPTOM SURVEY

DATE_____

PATIENT'S NAME_____ AGE_____

WEIGHT_____ HEIGHT_____ BLOOD PRESSURE_____ PULSE_____ O_2_____

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

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder L25.9
002 ☐ Acne L70.8
003 ☐ Psoriasis L40.8
004 ☐ Urticaria (Hives) L50.9
005 ☐ ADD/ADHD F90.1/F90.9
006 ☐ Allergies, Unspecified J30.9
007 ☐ Allergic Rhinitis from food J30.5
008 ☐ Sinusitis J01.90
009 ☐ Alzheimer's G30.9
010 ☐ Poor Concentration/Memory F07.8
011 ☐ Parkinson's Disease G20
012 ☐ Anemia D64.9
013 ☐ Arthritic Disorder M12.9
014 ☐ Osteoporosis M81.0
015 ☐ Asthma J45.909
016 ☐ Emphysema J43.9
017 ☐ Cancer
- 018 ☐ Breast C50.919female C50.929male
- 019 ☐ Prostate C61
- 020 ☐ Lung C34.90
- 021 ☐ Colon and Rectal C18.9
- 022 ☐ Skin C44.90
- 023 ☐ Leukemia w/o remission C95.90 Leukemia w/ remission C95.91
- 024 ☐ Lymphoma, malignant C85.89
- 025 ☐ Brain Tumor, malignant C71.9

027 ☐ Anxiety Disorder F41.9
028 ☐ Autism F84.0
033 ☐ Edema R60.9
034 ☐ Eczema L25.9
035 ☐ Chronic Fatigue R53.82
036 ☐ Circulatory Disorder I99.9
037 ☐ Heart Disease I51.9
038 ☐ High Cholesterol E78.0
039 ☐ High Blood Pressure I10
040 ☐ Low Blood Pressure I95.9
041 ☐ Tachycardia (High Heart Rate) R00.0
042 ☐ Numbness R20.9
043 ☐ Constipation K59.00
044 ☐ Indigestion K30
045 ☐ Ulcerative Colitis K51.90
046 ☐ Depression F32.9
047 ☐ Diabetes Mellitus E11.9
030 ☐ Diabetes Type I E10.9
031 ☐ Diabetes Type II E11.65
029 ☐ Hyperglycemia [high blood sugar] R73.09
048 ☐ Hypoglycemia [low blood sugar] E16.2
049 ☐ Dizziness/Balance Problem R42
050 ☐ Ear Infection H65.90
051 ☐ Epstein Barr B27.90
052 ☐ Eye Problems H57.13
053 ☐ Cataracts H26.9
054 ☐ Glaucoma H40.9
055 ☐ Macular Degeneration H35.30
056 ☐ Fever R50.9
057 ☐ Fibromyalgia M79.7
058 ☐ Gallbladder Disorder K82.9
059 ☐ Gout M10.9
060 ☐ Headaches R51
061 ☐ Hearing Loss H91.90
062 ☐ Infertility, male N46.9
064 ☐ Liver Disease K76.9
- 065 ☐ Hepatitis K71.6
- 066 ☐ Hepatitis B B16.9
- 067 ☐ Hepatitis C B17.10

068 ☐ Kidney Disorder N28.9 or Bladder Disorder N32.9
063 ☐ Prostate Disorder N42.9
069 ☐ Hyperthyroidism E05.90
070 ☐ Hypothyroidism E03.9
071 ☐ Systemic Lupus M32.10
072 ☐ Infertility, female M97.9
073 ☐ Interstitial Cystitis N30.11
074 ☐ Irregular Menstrual Cycle N92.6
075 ☐ Menopausal Symptoms N95.1
076 ☐ Hot Flashes N95.1
077 ☐ Mental Disorder F99
078 ☐ Insomnia G47.00
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores K12.0
081 ☐ Overweight E66.3
082 ☐ Underweight R63.6
083 ☐ Sexual Disorder F66
084 ☐ Spinal Problems M53.9
085 ☐ Obesity E66.9
086 ☐ GERD K21.9
087 ☐ HIV B20
088 ☐ Crohn's Disease K50.90
089 ☐ Irritable Bowel Syndrome K58.9
092 ☐ Normal Pregnancy Z33.1
**only applicable if *currently* pregnant
093 ☐ Shingles B02.9
140 ☐ Migraines G43.909
141 ☐ Rheumatoid Arthritis M06.9
142 ☐ Non-Systemic Lupus L93.0
143 ☐ Multiple Sclerosis G35
144 ☐ ALS (Lou Gehrig's) G12.21
145 ☐ Polymyalgia Rheumatica M35.3
146 ☐ Scleroderma M34.9
171 ☐ Goiter E04.9
178 ☐ Raynaud's Syndrome I73.00
179 ☐ Hemochromatosis E83.119
180 ☐ Thalassemia D56.8
181 ☐ Brain aneurysm I61.9

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 ☐ Hemorroidectomy
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 ☐ Bloated 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.

DRUG	PRESCRIBED FOR:	HOW LONG

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

DRUG	PRESCRIBED FOR:	HOW LONG

Allergies

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

- ☐ Dairy
- ☐ Eggs
- ☐ Garlic
- ☐ Gluten
- ☐ Mold
- ☐ Peanut
- ☐ Ragweed
- ☐ Shellfish
- ☐ Soy
- ☐ Sulfa drugs
- ☐ Tree nuts
- ☐ Wheat
- ☐ Other _____

Supplements

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

VITAMIN	BRAND	DOSAGE

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

Part I

Circle any of the following medications you are taking:

Antacids
High Blood Pressure
Antibiotic/Antifungal
Antidepressants
Thyroid
Other _____

Antidiabetic/Insulin
Laxatives
Aspirin/Tylenol
Chemotherapy
Ulcer Medications

Cortisone/Anti-inflammatories
Radiation
Lithium
Heart Medications
Oral Contraceptives Specify _____

High Blood Pressure
Relaxants/Sleeping Pills
Recreational Drugs
Hormones

Circle if you eat, drink or use:

Alcohol
Coffee
Luncheon meats
Chew Tobacco

Candy
Distilled water
Margarine
Vitamins and/or minerals (Please list) _____

Carbonated beverages
Eat at fast food restaurants regularly
Refined sugars

Cigarettes
Fried Foods
Saccharine

Circle if you:

Diet often
Are exposed to chemicals at work

Do not exercise regularly
Are exposed to cigarette smoke

Salt food without tasting

Are under excessive stress

Instructions: Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.
0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

Part II

Section A:

1. Does your stomach bloat after meals	0	1	2	3
2. Fullness for extended time after meals	0	1	2	3
3. Do you burp frequently	0	1	2	3
4. Does the above conditions alter your sleep	0	1	2	3
5. Does your stomach upset easily	0	1	2	3
6. Do you have a history of constipation	0	1	2	3
7. Known food allergies	0	1	2	3
8. Does fasting affect your stomach	0	1	2	3

Section B:

1. Do you have lower bowel gas	0	1	2	3
2. Is your stomach up set after eating	0	1	2	3
3. Are your tired after eating	0	1	2	3
4. Do you frequently have diarrhea	0	1	2	3
5. Alternating constipation and diarrhea	0	1	2	3
6. Do you have abdominal cramps	0	1	2	3
7. Roughage and fiber causes constipation	0	1	2	3
8. Does fiberous food irritate your diarrhea	0	1	2	3
9. Are your stools poorly formed	0	1	2	3
10. Do you have foul smelling stools	0	1	2	3
11. Do you have frequently daily bowel movements	0	1	2	3
12. Do you have shiny stools	0	1	2	3
13. Dry, flaky skin and/or dry brittle hair	0	1	2	3
14. Pain in left side under rib cage	0	1	2	3
15. Acne	0	1	2	3
16. Food allergies	0	1	2	3
17. Do you have difficulty gaining weight	0	1	2	3
18. Do you have mucous in your stools	0	1	2	3
19. Has a Doctor told you that you have colitis	NO	YES		

Section C:

1. Do you depend on antacids	0	1	2	3
2. Stomach pains just before and/or after meals	0	1	2	3
3. Do you have stomach pain at any time	0	1	2	3
4. Chronic abdominal pain	0	1	2	3
5. Do you have butterfly sensations in stomach	0	1	2	3
6. Do you have difficulty belching	0	1	2	3
7. Stomach pain when emotionally upset	0	1	2	3
8. Has a Doctor told you that you have ulcers	NO	YES		
9. Sudden, acute indigestion	NO	YES		
10. Is your condition worse at work	NO	YES		
11. Is your condition relieved by a vacation	NO	YES		
12. Relief of symptoms by carbonated beverages	NO	YES		
13. Relief of stomach pain by drinking cream/milk	NO	YES		
14. History of ulcer or gastritis	NO	YES(10)		
15. Does eating between meals help your stomach	NO	YES		
16. Do you have a current ulcer NO YES				
17. Black stool when not taking iron supplements	NO	YES(10)		

Section D:

1. Do you have stomach or abdominal cramps	0	1	2	3
2. Frequent and recurrent infections (colds)	0	1	2	3
3. Frequent bladder and kidney infections	0	1	2	3
4. Do you have seasonal diarrhea	0	1	2	3
5. Do you have frequent vaginal yeast infection	0	1	2	3
6. Do you have vaginal or genital itching	0	1	2	3
7. Toe and fingernail fungus	0	1	2	3
8. Alternating diarrhea/constipation	0	1	2	3
9. Constipation	0	1	2	3
10. Do you have a history of antibiotic use	NO	YES		
11. Meat eater	NO	YES		
12. Rapidly failing vision	NO	YES		

Part III

Section A:

1. Intolerance to greasy foods	0	1	2	3
2. Headaches after eating	0	1	2	3
3. Light colored stool	0	1	2	3
4. Foul smelling stool	0	1	2	3
5. Less than one bowel movement daily	0	1	2	3
6. Constipation	0	1	2	3
7. Hard stool	0	1	2	3
8. Sour taste in mouth	0	1	2	3
9. Gray colored skin	0	1	2	3
10. Yellow in whites of eyes	0	1	2	3
11. Bad breath	0	1	2	3
12. Body odor	0	1	2	3
13. Fatigue and sleepiness after eating	0	1	2	3
14. Pain in right side under rib cage	0	1	2	3
15. Painful to pass stool	0	1	2	3
16. Retain water	0	1	2	3
17. Big toe painful	0	1	2	3
18. Pain radiates along outside of leg	0	1	2	3
19. Dry skin/hair	0	1	2	3
20. Red blood in stool	NO	YES (6)		
21. Have you had jaundice or hepatitis	NO	YES		
22. High blood cholesterol and low HDL cholesterol	NO	UNKNOWN		YES
23. Is your cholesterol level above 200	NO	UNKNOWN		YES
24. Is your triglyceride level above 115	NO	UNKNOWN		YES

Part III Continued

Section B:

1. Swollen eyes (bulging)	0	1	2	3
2. Strong smelling urine	0	1	2	3
3. Thick skin and finger nails	0	1	2	3
4. Dry skin	0	1	2	3
5. Sensitive to the cold	0	1	2	3
6. Cold hands and feet	0	1	2	3
7. Excessive menstrual bleeding	0	1	2	3
8. Chronic fatigue	0	1	2	3
9. Trouble waking up in the morning	0	1	2	3
10. Depressed, apathetic	0	1	2	3
11. Low sex drive	0	1	2	3
12. Puffy, wrinkle skin	0	1	2	3
13. Sugar causes irritability and mood swings	0	1	2	3
14. Premenstrual tension	0	1	2	3
15. Constipation	0	1	2	3
16. Thinning or loss of outside portion of eyebrow	NO	YES		
17. Gain weight easily	NO	YES		
18. Anemia unaffected by iron	NO	YES		
19. Axillary (armpit) temperature below 97.6F	NO	YES		
20. Slow reflexes	NO	YES		
21. Infertility	NO	YES		

Part IV

Section A:

1. Sensitive to exhaust fumes, smoke, smog, petrochemicals	0	1	2	3
2. Periodic constipation	0	1	2	3
3. Cannot tolerate much exercise	0	1	2	3
4. Depression or rapid mood swings	0	1	2	3
5. Dark circles under the eyes	0	1	2	3
6. Dizziness upon standing	0	1	2	3
7. Lack of mental alertness	0	1	2	3
8. Catch colds easily when weather changes	0	1	2	3
9. Headaches	0	1	2	3
10. Difficulty breathing	0	1	2	3
11. Water retention	0	1	2	3
12. Eyes sensitive to bright light	0	1	2	3
13. Feel weak and shaky	0	1	2	3

Section B:

1. Inflamed or bleeding gums	0	1	2	3
2. Running nose	0	1	2	3
3. Get boils or styes	0	1	2	3
4. Nose bleeds	0	1	2	3
5. Loss of smell	0	1	2	3
6. Throat infections	0	1	2	3
7. Cold sores, fever blisters	0	1	2	3
8. Loss of taste	0	1	2	3
9. Poor wound healing	0	1	2	3
10. Hair falls out	0	1	2	3
11. Swollen lymph glands	0	1	2	3
12. Ear infection	0	1	2	3
13. Hair grows slowly	0	1	2	3
14. Slow to recover from cold or flu	0	1	2	3
15. Catch colds or flu easily	0	1	2	3
16. Bumpy skin on back of arms	0	1	2	3

Section C:

1. Itching of nose or eyes	0	1	2	3(5)
2. Itching of roof of mouth or throat	0	1	2	3(5)
3. Migraine headaches	NO	YES(10)		
4. Entire body aches, painful to touch	0	1	2	3
5. Swollen joints	0	1	2	3
6. Food sensitivity or allergy	0	1	2	3
7. Certain foods make you sick, depressed, jittery	0	1	2	3
8. Chronic pain	0	1	2	3
9. Painful stomach and/or intestine	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Mucous in throat	0	1	2	3
12. Post nasal drip	0	1	2	3
13. Discharge from eyes	0	1	2	3
14. Watery eyes	0	1	2	3
15. Puffiness or dark circles under eyes	0	1	2	3
16. Ear discharge or ears stuffed up	0	1	2	3
17. Nasal congestion	0	1	2	3
18. Running nose	0	1	2	3
19. Breathe through mouth	0	1	2	3
20. Swollen tongue	0	1	2	3
21. Difficulty swallowing	0	1	2	3
22. Bed wetting	N0	YES (5)		
23. Hyperactivity	0	1	2	3
24. Chronic lung congestion	0	1	2	3
25. Use aspirin, Tylenol regularly	NO	YES		
26. Wheezing	0	1	2	3
27. Skin rashes	0	1	2	3
28. Sneezing	0	1	2	3

Part V

Section A:

1. Difficulty breathing at night	0	1	2	3
2. Chest pain while walking	0	1	2	3
3. Heaviness in legs	0	1	2	3
4. Calf muscles cramp while walking	0	1	2	3
5. Heart pounds easily	0	1	2	3
6. Feel jittery	0	1	2	3
7. Heart misses beats or has extra beats	0	1	2	3
8. Swelling of feet and ankles	0	1	2	3
9. Rapid beating heart	0	1	2	3
10. Heartburn after eating	0	1	2	3
11. Pain in left arm	0	1	2	3
12. Exhaust with minor exertion	0	1	2	3
13. Do you do aerobic exercise?	NO	YES		
14. Have you ever exercised regularly?	NO	YES		
15. Drink 5 or more cups of coffee daily	NO	YES		
16. Severe cough	NO	YES		
17. Has a doctor ever told you that you have heart trouble?	NO	YES		

Section B:

1. Cold hands and feet	0	1	2	3
2. Slurred speech	0	1	2	3
3. Calf muscles cramp while walking	0	1	2	3
4. Headaches	0	1	2	3
5. Numbness in extremities	0	1	2	3
6. Poor concentration	0	1	2	3
7. Ringing in ears	0	1	2	3
8. Ear canal hair	NO	YES		
9. Tingling and/or burning in hands or feet	NO	YES		
10. Spider veins on nose and/or face	NO	YES		

Section C:

1. Pain when getting up in morning in back of head and neck	0	1	2	3
2. Dizziness	0	1	2	3
3. Vertigo	0	1	2	3
4. Blushing with no apparent cause	0	1	2	3
5. Is your blood pressure high?	NO	YES(10)		

Part VI

Section A:

1. Dizziness when standing suddenly 0 1 2 3
2. Loss of vision when standing suddenly 0 1 2 3
3. Crave sweets 0 1 2 3
4. Headaches relieved by eating sweets or alcohol 0 1 2 3
5. Feel shaky or jittery 0 1 2 3
6. Irritable if a meal is missed 0 1 2 3
7. Wake up in middle of night craving sweets 0 1 2 3
8. Feel tired or weak if a meal is missed 0 1 2 3
9. Heart palpitations after eating sweets 0 1 2 3
10. Need to drink coffee to get started 0 1 2 3
11. Impatient, moody, nervous 0 1 2 3
12. Feel tired 1 to 3 hours after eating 0 1 2 3
13. Poor memory 0 1 2 3
14. Feel faint 0 1 2 3
15. Poor concentration 0 1 2 3
16. Forgetful 0 1 2 3
17. Calmer after eating NO YES

Section B:

1. Night sweats 0 1 2 3
2. Increased thirst 0 1 2 3
3. Lowered resistance to infection 0 1 2 3
4. Fatigue 0 1 2 3
5. Boils and leg sores 0 1 2 3
6. Lesions, cuts take a long time to heal 0 1 2 3
7. Overweight 0 1 2 3
8. Feel pick up from exercise 0 1 2 3
9. Failing eyesight 0 1 2 3
10. Crave sweets, but eating sweets does not relieve symptoms 0 1 2 3
11. Family history of diabetes 0 1 2 3
12. Sugar in urine NO YES

Part VII

1. Chest pain 0 1 2 3
2. Chronic cough 0 1 2 3
3. Difficulty breathing 0 1 2 3
4. Coughing up blood 0 1 2 3
5. Coughing up phlegm 0 1 2 3
6. Pain around ribs 0 1 2 3
7. Shortness of breath 0 1 2 3
8. Rattling mucous when you breathe 0 1 2 3
9. Sensitive to smog 0 1 2 3
10. Infections settle in lungs 0 1 2 3
11. Live or work around people who smoke 0 1 2 3
12. Bronchitis NO YES(10)
13. Exposed to chemicals and radiation NO YES(6)
14. Smoker NO YES(6)

Part VIII

1. Frequent urination 0 1 2 3
2. Frequent bladder infections 0 1 2 3
3. Rarely need to urinate 0 1 2 3
4. Urination when you cough or sneeze 0 1 2 3
5. Painful/burning when passing urine 0 1 2 3
6. Difficulty passing urine 0 1 2 3
7. Dripping after urination 0 1 2 3
8. Can't hold urine 0 1 2 3
9. Rose colored (bloody) urine 0 1 2 3
10. Cloudy urine 0 1 2 3
11. Strong smelling urine 0 1 2 3
12. Back or leg pains associated with dripping after urination 0 1 2 3
13. History of kidney or bladder infections NO YES
14. Have used antibiotics to control urinary tract infections NO YES
    If yes, when did you last use them_____
    Treatment duration_____
15. Back pain in the kidney area 0 1 2 3
16. General water retention 0 1 2 3

Part IX (Males only)

Section A:

1. Difficulty urinating 0 1 2 3
2. A sense of bladder fullness 0 1 2 3
3. Increased straining with smaller and smaller amounts of urine passed 0 1 2 3
4. Rose colored (bloody) urine 0 1 2 3
5. Pain or burning while urinating 0 1 2 3
6. Wake up to urinate at night 0 1 2 3
7. Dripping after urination 0 1 2 3
8. Pain or fatigue in the legs or back 0 1 2 3
9. Lack of sex drive 0 1 2 3
10. Ejaculation causes pain 0 1 2 3

Section B:

1. Difficulty attaining and/or maintaining an erection 0 1 2 3
2. Low sexual drive 0 1 2 3
3. Premature ejaculation 0 1 2 3
4. Pain/coldness in genital area 0 1 2 3
5. Infertile NO YES(5)
6. Varicose veins on scrotum NO YES
7. Low sperm count NO YES (5)

Section C:

1. Discharge from penis 0 1 2 3
2. Past or present rash on penis 0 1 2 3
3. Swollen genitals 0 1 2 3
4. Swelling in groin 0 1 2 3
5. Venereal disease (gonorrhea, syphilis, herpes or other) NO YES (9)
   Have V.D. now?_____ Had is past?_____

Part X (Females only)

Section A:

Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation.(Section A only)

1. Monthly weight gain 0 1 2 3
2. Depression 0 1 2 3
3. Moodiness/irritability 0 1 2 3
4. Bloating and swelling 0 1 2 3
5. Nausea and/or vomiting 0 1 2 3
6. Suicidal feeling NO YES(10)
7. Anxiety 0 1 2 3
8. Leg cramps and tenderness 0 1 2 3
9. Asthma attacks NO YES(10)
10. Headaches 0 1 2 3
11. Easily distracted 0 1 2 3
12. Anger 0 1 2 3
13. Tender breasts 0 1 2 3
14. Low backache 0 1 2 3
15. Other_____

Section B:

1. Vaginal itching 0 1 2 3
2. Vaginal discharge 0 1 2 3
3. Low or no desire for sex 0 1 2 3
4. Dislike for intercourse 0 1 2 3
5. Missed periods NO YES
6. Over 15 years of age and have not begun menstruation NO YES
7. Unable to get pregnant NO YES
8. Miscarriages
   NO YES
   HOW MANY_____
9. Abortion
   NO YES
   HOW MANY?_____

Part X (Females only) Continued

Section C:

Check if you experience any of these symptoms during menstruation. (Section C only)

1. Low abdominal pain 0 1 2 3
2. Dull ache radiating to low back or legs 0 1 2 3
3. Increased urinary frequency 0 1 2 3
4. Pelvic soreness 0 1 2 3
5. Diarrhea 0 1 2 3
6. Headaches 0 1 2 3
7. Abdominal bloating 0 1 2 3
8. Menstrual pain 0 1 2 3
9. Nausea and/or vomiting 0 1 2 3
10. Have to lie down on first 1 or 2 days of period 0 1 2 3
11. Craving for sweets 0 1 2 3
12. Insomnia 0 1 2 3
13. Light scanty blood flow 0 1 2 3
14. Pain and cramps without blood flow 0 1 2 3
15. Heavy menstrual bleeding 0 1 2 3
16. Anxiety about menstrual cycle 0 1 2 3
17. Pain during period is progressively getting worse with time 0 1 2 3

Section D:

1. Vaginal bumps and sores 0 1 2 3
2. Pubic area sore 0 1 2 3
3. Ovarian cysts NO YES(10)
4. Uterine cysts NO YES(10)
5. Pain in ovaries 0 1 2 3
6. Breast lumps NO YES(10)
7. Breasts sore to touch 0 1 2 3
8. Breasts painful 0 1 2 3
9. Water retention 0 1 2 3
10. Swollen feeling 0 1 2 3
11. Premenstrual breast pain or discomfort 0 1 2 3
12. Mother used D.E.S. (hormones) while pregnant NO YES
13. Recent pap smear positive NO YES(15)
14. Family history of breast cancer NO YES
15. Form of birth control: ___None ___Pill ___IUD ___Sponge ___Diaphragm ___Foam

Other _____

Section E:

1. Hot flashes 0 1 2 3
2. Night sweats 0 1 2 3
3. Hysterectomy NO YES
4. Depression/mood swings 0 1 2 3
5. Insomnia 0 1 2 3
6. Craving for sweets 0 1 2 3
7. Heavy bleeding two weeks/month 0 1 2 3
8. Sweating throughout day 0 1 2 3
9. Dryness of skin, hair, and vagina 0 1 2 3
10. Painful intercourse 0 1 2 3
11. Vaginal pain 0 1 2 3
12. Vaginal itching 0 1 2 3
13. Osteoporosis (Bone loss) NO YES

Part XI

Section A:

1. Pain in fingers 0 1 2 3
2. Bones sore/painful 0 1 2 3
3. Eat meat 0 1 2 3
4. Cavities 0 1 2 3
5. Arthritis 0 1 2 3
6. Drink carbonated beverages/soda _____ oz. per week YES
7. Gum disease NO YES
8. Bone loss NO YES
9. Calcium deposits NO YES
10. Use antacids _____ # per week YES
11. Dentures NO YES
12. Bone deformity NO YES
13. Told you have osteoporosis/osteomalacia NO YES(5)
14. Recent bone fracture NO YES
15. Are you post menopausal NO YES

Section B:

1. Muscle spasms 0 1 2 3
2. Tightness in shoulder muscles 0 1 2 3
3. Muscle cramps 0 1 2 3
4. Pain in arms, hands 0 1 2 3
5. Leg cramps at night 0 1 2 3
6. Stiff all over 0 1 2 3
7. Stiff in morning 0 1 2 3
8. Unable to sit straight 0 1 2 3
9. Pain in neck and/or shoulders 0 1 2 3
10. Back pain 0 1 2 3

Section C:

1. Over flexible joints (double-jointed) 0 1 2 3
2. Back pain 0 1 2 3
3. Swollen knees/elbows 0 1 2 3
4. Athletic injury 0 1 2 3
5. Bursitis 0 1 2 3
6. Tendonitis 0 1 2 3
7. Joint pain 0 1 2 3
8. Slipped disc NO YES(5)
9. Herniated disc NO YES(10)
10. Loss in height NO YES
11. Injure easily NO YES

Part XII

1. Head feels heavy 0 1 2 3
2. Light headedness/fainting 0 1 2 3
3. Loss of balance 0 1 2 3
4. Dizziness 0 1 2 3
5. Ringing/buzzing in ears 0 1 2 3
6. Trembling hands 0 1 2 3
7. Loss of feeling in hands and/or feet (toes) 0 1 2 3
8. Exhaustion on slightest effort 0 1 2 3
9. Limbs feel too heavy to hold up 0 1 2 3
10. Loss of grip strength 0 1 2 3
11. Tingling pain sensation 0 1 2 3
12. Convulsions NO YES(10)
13. Incoordination 0 1 2 3
14. Nervousness 0 1 2 3
15. Accident prone NO YES
16. Loss of muscle tone NO YES
17. Need for 10-12 hours sleep NO YES
18. Have had shingles NO YES

Part XIII

1. Nightmares 0 1 2 3
2. Can't fall asleep 0 1 2 3
3. Intense dreams 0 1 2 3
4. Leg cramps/restless leg at night 0 1 2 3
5. Restless, uneasy sleeper 0 1 2 3
6. Awake frequently throughout night NO YES
7. Wake up in the middle of night, can't fall back to sleep NO YES
8. Sleep walk NO YES

Do you have any other symptoms that have not been covered in the questionnaire?

_____

_____

_____

_____

_____

10

Adrenal Thyroid Symptom Questionnaire (ATSQ)

(Assessment signs and symptoms of adrenal fatigue compared to low thyroid function)

Date: _____ Patient: _____

Instructions: Please circle the box (**Adrenal, Mixture, or Thyroid**) that most describes your symptoms related to each **AREA** listed on the left.

AREA	Adrenal	Mixture	Thyroid
Body type	Mild: gains weight easily Moderate: can't lose weight Severe: thin, cant gain weight	Gains weight easily esp. around hips and waist	Weight gain, generalized, extremely hard to lose
Face shape	Eyes and cheeks appear sunken when severe	normal	Full, puffy around eyes
Eyebrows	Tend to be full	Normal to sparse	Very sparse(esp. lateral 1/3)
Eyes	Sunken appearance , may have dark circles	Normal or some "bags" under the eyes	Puffy around the eyes, often with "bags' under the eyes
Facial coloring	Tendency to pallor, esp. around the mouth. In dark skin, it darkens around the mouth, forehead and sides of face	Pallor around the mouth	Reddish or rosy complexion
Hair	Thin, dry, sparse on forearms and legs	Tendency to be sparse	Tends to be course and, sparse. Hair loss
Nails	Thin and brittle	Break easily	May be thick
Skin quality	Dry, thin , smooth finger prints, longitudinal wrinkles over finger pads	May be thin, dry, bruise easily, poor healing	Course, dry scaly, and thick (can be oily)
Temperature Pattern	Cold when it's cold. Hot when it's hot	Fluctuating pattern, averages on the low side	Stable and low
Immune function	Tends to over-react (allergies, autoimmune, sensitivities)	Mixed	Tends to under- response (possible chronic infections)
Sleep pattern	Insomnia, light sleeper, waking in the middle of the night	May or may not have sleep disturbances	Sleepiness
Energy pattern	Wired and tired	Mixed	Tired, sluggish
Exercise tolerance	Causes fatigue	Mixed	Tires easily
Blood pressure	Tends to run low	Mixed	generally normal – low in severe cases
Carpal tunnel syndrome			May be present
Fluid	Can't hold water	Mixed	Retains fluid
Bowel function	Tendency to be irritable	Mixed	Tendency toward constipation
Cravings	Sweets, salt	mixed	Fats

Comments: _____

Doctor use only

NAME _____ DATE ____/____/____

	Part II. Digestion				Part III. Fat Metabolism		Part IV. Immune Function			Part V. Cardiovascular			Part VI. Sugar Tolerance		VII. Lung	VIII. Urological	Part IX. Male			Part X. Female					Part XI. Musculoskeletal			XII.	XIII.
	A Hypoacidity	B. Small Intestine	C. Hyperacidity	D. Colon	A Liver/gallbadder	B. Thyroid	A. Hypoadrenal	B. Hypoimmune	C. Hyperimmune	A Heart	B. Circulation	C. Hypertension	A Hypoglycemia	B. Hyperglycemia	Lungs	Urological	A. Prostate	B. Reproduction	C. Genital Infection	A PMS	B. Amenorrhea	C. Dysmenorrhea	D. Fibrocystic Problems	E. Menopause	A Bone integrity	B. Muscle	C. Connective Tissue	Neurological	Sleep patterns
100	15+	15+	15+	15+	18+	25+	20+	30+	45+	15+	15+	9+	21+	24+	15+	21+	15+	15+	9+	25+	15+	30+	30+	19+	15+	15+	12+	30+	9+
HIGH PRIORITY	13	13	13	13	15	20	18	25	35	13	13	8	18	21	13	18	12	12	7	20	12	27	25	17	13	12	9	25	8
	11	11	11	11	12	15	16	20	25			7	15	18	11	15				15		24	20	15				20	7
75	9	9	9	9	9	12	14	15		11	11	6	12	12	9	9	9	9	5	11	9	21	15	11	11	9	7	15	6
																								9					
MODERATE PRIORITY	7	7	7	7	5	7	9	9	10	9	9	5	9	9	6	6	7	7	4	8	6	15	12	7	9	7	5	10	5
50					4							4					5	5	3			12		5	7	5			4
					3																	9		3					
	5	5	5	5		5	6	6	5	7	7	3	6	6	3	3	3	3		5	3	6	9		5	3	3	5	3
																			2										
25					2				3						2					3	2	3	5	2	3	2	2	3	2
LOW PRIORITY	3	3	3	3		3	3	3		4	4	2	3	3		2	2	2											
					1							1			1				1										
0	1	1	1	1		1	1	1	1	1	1		1	1		1	1	1		1	1	1	1	1	1	1	1	1	
Score																													

19

NAME_____

DATE_____

Two week Dietary Profile (Please complete for 14 days prior to office visit.)

MONDAY BM[1] AM ____ PM ____	BREAKFAST	SNACK	LUNCH	SNACK	DINNER
TUESDAY BM AM ____ PM ____					
WEDNESDAY BM AM ____ PM ____					
THURSDAY BM AM ____ PM ____					
FRIDAY BM AM ____ PM ____					
SATURDAY BM AM ____ PM ____					
SUNDAY BM AM ____ PM ____					

[1] BM – Bowel Movement; please state time of day

NAME_____

DATE_____

Two week Dietary Profile (Please complete for 14 days prior to office visit.)

MONDAY BM[1] AM ____ PM ____	BREAKFAST	SNACK	LUNCH	SNACK	DINNER
TUESDAY BM AM ____ PM ____					
WEDNESDAY BM AM ____ PM ____					
THURSDAY BM AM ____ PM ____					
FRIDAY BM AM ____ PM ____					
SATURDAY BM AM ____ PM ____					
SUNDAY BM AM ____ PM ____					

[1] BM – Bowel Movement; please state time of day

14