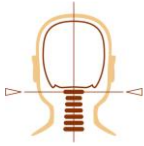


BALANCED LIVING CHIROPRACTIC

□ 441 SOUTH LIVERNOIS • SUITE 265 • ROCHESTER HILLS, MI 48307 • 248.652.7225

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION (PLEASE PRINT**)** **DATE:**______________________________

NAME____ SOCIAL SECURITY#_____________________

ADDRESS____

CITY____STATE__________________ZIP_____________________

HOME PHONE__________________________CELLPHONE______________________EMAIL______________________________

BIRTH DATE___________________________ MARRIED SINGLE NO. OF CHILDREN______________________________

SPOUSE NAME____

EMPLOYED BY_____________________________________OCCUPATION____

REFERRED BY____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE YES NO COMPANY____

EFFECTIVE JANUARY 1ST, 2013

I ACKNOWLEDGE THAT IF I DO NOT SHOW UP, OR CALL THE OFFICE 24 HOURS PRIOR TO MY APPOINTMENT THAT I AM DIRECTLY RESPONSIBLE FOR A $25.00 CANCELLATION/MISSED APPOINTMENT FEE.

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE IN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT THIS OFFICE TO ENDORSE CO-ISSUED REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

Terms of Acceptance

When a person enters this office for care, it is essential that we are both working towards the same objectives.

Chiropractic has only one objective. It is important for us to establish a clear understanding of the philosophy and procedures of this office so that there is no confusion.

A state of optimal physical, social, and mental well-being and not just merely the absence of disease or symptoms. Without interference, the nervous system is able to coordinate all the body's systems and function.

Accidents and injuries create a weakness in the body that allows the spine to lock in a stressed position. This stressed position leads to imbalances in the spine showing up as postural distortion, and leads to nervous imbalance.

Once the spine moves into a stressed position the entire spine is affected, showing spinal distortions and creating pressure on the spinal cord. This interference can lead to abnormal function anywhere in the body.

Diagnosing and treating disease (or its symptoms) is the practice of medicine. Chiropractic is not medicine and does not diagnose or treat disease. At Balanced Living Chiropractic we are concerned with adding health to the body, not treating the lack of it. Whatever stage of health you are in, you can benefit from a properly functioning nervous system. If during your care we find something out of the ordinary, we will notify you. If it is not Chiropractic in nature it will be your responsibility to seek care with the appropriate professional.

Our objective is to balance your spine, thus removing nervous system interference and allow the body to heal itself and function at 100% of its potential.

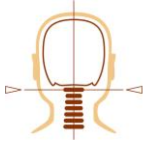
"I understand the above statement and choose to accept care under these terms"

______________________________ ________________

Signature (legal guardian if under 18) Date

____

Print name (or name of minor)



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Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that Balanced Living Chiropractic, PLLC.'s "Notice of Privacy Practices" has been provided to me.

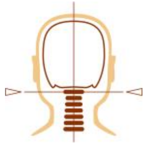
I understand I have the right to review Balanced Living Chiropractic PLLC.'s Notice of Privacy Practices prior to signing this document. Balanced Living Chiropractic, PLLC.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my bills or in the performance of health care operations of Balanced Living Chiropractic, PLLC. The Notice of Privacy Practices for Balanced Living Chiropractic, PLLC. Is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Balanced Living Chiropractic PLLC.'s duties with respect to my protected health information.

Balanced Living Chiropractic, PLLC. Reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy by calling the office, and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____________________________________ _____________
Signature of Patient or Personal Representative **Date**

____________________________________ _____________
Name of Patient or Personal Representative **Date**

____
Description of Personal Representative Authority



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PATIENT INTAKE FORM

PATIENTS NAME:_______________________________________DATE:___/___/_____

1) Please choose the location(s) of your problem(s):

Headaches	Shoulder	Hand	Legs
Jaw	Arm	Mid Back	Knee
Neck	Elbow	Low Back	Ankle
Upper Back	Wrist	Hip	Foot

Other:____

2) What is your height? ________ft. ________in.
3) How much do you weight? ________lbs.
4) DOB ______/______/_________
5) Occupation:

Trader	Professional/Executive	White Collar	Tradesperson	Retired
Laborer	Homemaker	Truck driver	Student	Unemployed

Other:____

6) In general, how do you rate your overall health?

Excellent	Very good	Good	Fair	Poor

7) What kind of exercise do you perform?

Strenuous	Moderate	Light	None

8) Do you have an immediate family member with any of the following?

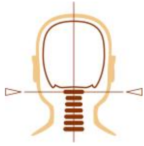
Rheumatoid Arthritis	Heart Problems	Diabetes
Cancer	Lupus	ALS

Other:____

9) Please check all that apply to you in the appropriate 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			Smoking/Tobacco Use
		Low Back Pain			Angina			Drug/Alcohol Dependence
		Shoulder Pain			Kidney Stones			Allergies
		Elbow/ Upper Arm Pain			Kidney Disorders			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			HIV/AIDS
		Knee Pain			Abnormal Weight Gain/Loss			
		Ankle/Foot Pain			Loss of Appetite			**For Females Only**
		Jaw Pain			Abdominal Pain			Birth Control Pills
		Joint Pain/Stiffness			Ulcer			Hormonal Replacement
		Arthritis			Hepatitis			Pregnancy
		Rheumatoid Arthritis			Liver/Gall Bladder Disorder			
		Cancer			General Fatigue			
		Tumor			Muscular Incoordination			
		Chronic Sinusitis			Dizziness			

Other____



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PATIENT INTAKE FORM

10) Please list all prescription medications you are currently taking:

____

11) Please list all supplements you are currently taking:

____

12) Please list all surgical procedures you have had:

____

13) What do you do at work?

Sits most of the day	Sits about half of the day	Sits a little of the day
Stands most of the day	Stands about half of the day	Stands a little of the day
Computer most of the day	Computer about half the day	On the phone a little of the day
Drives most of the day	Drives about half the day	Travels frequently a little of the day
None		

Other: ____

14) What do you do outside of work?

Aerobics	Skiing	Basketball	Soccer	Baseball	Softball
Bicycling	Swimming	Football	Tennis	Golf	Triathlons
Hiking	Volleyball	Ice Hockey	Walking	Inline skating	Weight lifting
Jogging	Working out	Martial arts	Yoga	Rock climbing	Other

15) Have you had any hospitalizations?

YES	NO	Previously Mentioned

16) Have you seen a chiropractor before?

YES	NO

17) Have you had any significant past trauma?

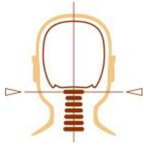
YES	NO

18) Is there anything else you think I should know?

YES	NO

19) What did the patient score on the revised neck Oswestry index? ______________________________

20) What did the patient score on the revised lower back Oswestry index? __________________________



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Neck Disability Index (IF YOU DO NOT HAVE A NECK COMPLAINT, PLEASE SKIP THIS PAGE!)

This Questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

I have no pain at the moment. (0)
The pain is very mild at the moment. (1)
The pain is moderate at the moment. (2)
The pain is fairly severe at the moment. (3)
The pain is very severe at the moment. (4)
The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

I can look after myself normally without causing extra pain. (0)
I can look after myself normally but it causes extra pain. (1)
It is painful to look after myself and I am slow and careful. (2)
I need some help but manage most of my personal care. (3)

I need help every day in most aspects of self care. (4)
I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

I can lift heavy weights with out extra pain. (0)
I can lift heavy weights but it gives me extra pain. (1)
Pain prevents me from lifting heavy weights off the floor, but I can Manage if they are conveniently positioned, for example on a table. (2)
I can lift very light weights. (4)
I cannot lift or carry anything at all. (5)

Section 4 – Reading

I can read as much as I want with no pain in my neck. (0)
I can read as much as I want with slight pain in my neck. (1)
I can read as much as I want with moderate pain in my neck. (2)
I cannot read as much as I want to because of moderate pain in my My neck. (3)
I can hardly read at all because of severe pain in my neck. (4)
I cannot read at all. (5)

Section 5 – Headaches

I have no headaches at all. (0)
I have slight headaches that come infrequently. (1)
I have moderate headache which come infrequently. (2)
I have moderate headaches which come frequently. (3)
I have severe headaches which come frequently. (4)
I have headaches almost all the time. (5)

Section 6 – Concentration

I can concentrate fully when I want to with no difficulty. (0)
I can concentrate fully when I want to with slight difficulty. (1)
I have a fair degree of difficulty in concentrating when I want to. (2)
I have a lot of difficulty in concentrating when I want to. (3)
I have a great deal of difficulty in concentrating when I want to. (4)
I cannot concentrate at all. (5)

Section 7 - Work

I can do as much work as I want to. (0)
I can do my usual work, but no more. (1)
I can do most of my usual work, but no more. (2)
I cannot do my usual work. (3)
I can hardly do any work at all. (4)
I cannot do any work at all. (5)

Section 8 – Driving

I can drive my car without any neck pain. (0)
I can drive my car as long as I want with slight pain in my neck. (1)
I can drive my car as long as I want with moderate pain in my neck. (2)
I cannot drive my car as long as I want because of the moderate pain in My neck. (3)
I can hardly drive at all because of my severe pain in my neck. (4)
I cannot drive my car at all. (5)

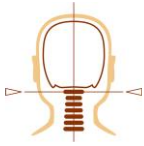
Section 9 – Sleeping

I have no trouble sleeping. (0)
My sleep is slightly disturbed (less than 1 hour sleepless). (1)
My sleep is mildly disturbed (1-2 hours sleepless). (2)
My sleep is moderately disturbed (2-3 hours sleepless). (3)
My sleep is greatly disturbed (3-5 hours sleepless). (4)
My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

I am able to engage in all my recreational activities with no neck pain at all. (0)
I am able to engage in all of my recreation activities, with some pain in my neck. (1)
I am able to engage in most, but not all, of my usual recreation because of pain in my neck. (2)
I am able to engage in a few of my usual recreation activities because Of the pain in my neck. (3)
I can hardly do any recreation activities because of pain in my neck. (4)
I cannot do any recreation activities at all. (5)

0-4	**No disability**
5-14	**Mild disability**
15-24	**Moderate disability**
25-34	**Severe disability**
>35	**Complete disability**



BALANCED LIVING CHIROPRACTIC

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Oswestry Disability Index

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 (Washing, Dressing, etc.)

I can look after myself normally but it is very painful.
I can look after myself normally but it is very painful.
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 with out 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 they are conveniently positioned, for example on a table
I can lift very light weights.
I cannot lift or carry anything at all.

Section 4 – Walking

Pain does not prevent me walking any distance.
Pain prevents me walking more than 1 mile.
Pain prevents walking more than ¼ of a mile.
Pain prevents me from walking more than 100 yards.
I can only walk using a stick or crutches
I am in bed most of the time and have to crawl to the toilet

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.
Pain prevents me from sitting at all.

Section 6 – Standing

I can stand as long as I want without extra pain.
I can stand as long as I want but it gives me extra pain.
Pain prevents me from standing more than 1 hour.
Pain prevents me from standing for more than ½ hour.
Pain prevents me from sitting for more than 10 minutes.
Pain prevents me from standing at all.

Section 7 - Sleeping

My sleep is never disturbed by pain.
My sleep is occasionally disturbed by pain.
Because of pain, I have less than 6 hours of sleep.
Because of pain, I have less than 4 hours sleep.
Because of pain, I have less t han 2 hours sleep..
I cannot do any work at all.

Section 8 – Sex Life (if applicable)

My sex life is normal and causes no extra pain.
My sex life is normal but causes some extra pain.
My sex life is nearly normal but is very painful.
My sex life is severely restricted by pain.
My sex life is nearly absent because of pain.
Pain prevents any sex life at all.

Section 9 – Social Life

My social life is normal and causes me no extra pain.
My social life is normal but increases the degree of pain
Pain has no significant effect on my social life apart from limiting my More energetic interest, i.e. sports.
Pain has restricted my social life and I do not go out as often.
Pain has restricted my social life to my home.
I have no social life because of pain.

Section 10 – Traveling

I can travel anywhere without pain.
I can travel anywhere but it gives extra pain.
Pain is bad but I manage journeys of over two hours.
Pain restricts me to short necessary journeys under 30 minutes.
Pain prevents me from traveling except to receive treatment.

Section 11 – Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.
No
Yes (If yes, please state the type of treatment you have received.)

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SYSTEMS SURVERY FORM (pg 1)

PATIENT___________________DOCTOR________________________DATE_________________________
AGE_____________PHONE(_______)______________________VEGETARIAN_________YES__________NO

INSTRUCTIONS: Circle the number that applies to you. **If symptom doesn't apply, leave blank.** Use (**1**) for **MILD** symptoms (occurs once or twice a month), (**2**) for **MODERATE** symptoms (occurs several times a month), and (**3**) for **SEVERE** symptoms (you are aware of it 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 up 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

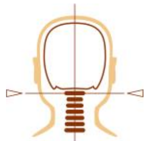
21 **- 1 2 3** Joint stiffness after arising
22 **- 1 2 3** Muscle-leg-toe cramps at night
23 **- 1 2 3** "Butterfly" stomach cramps
24 **- 1 2 3** Eyes or nose watery
25 **- 1 2 3** Eyes blink often
26 **- 1 2 3** Eyelids swollen, puffy
27 **- 1 2 3** Indigestion soon after meals
28 **- 1 2 3** Always seems 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, ashtma, 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 delays
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 sweet or snacks

GROUP FOUR

56 **- 1 2 3** Hands and feet go to sleep easily, numbness
57 **- 1 2 3** Sign 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



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SYSTEMS SURVERY FORM (pg 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 water
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 1/2 - 1 hour after eating; may be up to 3-4 hours
104 **- 1 2 3** Mucous colitis or "irritable bowel"
105 **- 1 2 3** Gas shortly after eating
106 **- 1 2 3** Stomach "bloating after eating

GROUP SEVEN

(A)

107 **- 1 2 3** Isomnia
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** Irritatible 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

(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 rending" 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

(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

menstrual function	
130 **- 1 2 3** Mental sluggishness	asthma
131 **- 1 2 3** Hair coarse, falls out	170 **- 1 2 3** Weakness after colds, Influenza
132 **- 1 2 3** Headaches upon arising wear off during day	171 **- 1 2 3** Exhaustion - muscular and nervous
133 **- 1 2 3** Slow pulse, below 65	
134 **- 1 2 3** Frequency of urination	172 **- 1 2 3** Respiratory disorders
135 **- 1 2 3** Impaired hearing	
136 **- 1 2 3** Reduced initiative	

SYSTEMS SURVERY FORM – Page 3

GROUP EIGHT

173 **- 1 2 3** Apprehension
174 **- 1 2 3** Irritability
175 **- 1 2 3** Morbid fears
176 **- 1 2 3** Never seems to get well
177 **- 1 2 3** Forgetfullness
178 **- 1 2 3** Indigestion
179 **- 1 2 3** Poor appetite
180 **- 1 2 3** Craving for sweets
181 **- 1 2 3** Muscular soreness
182 **- 1 2 3** Depression; feelings of dread
183 **- 1 2 3** Noise sensitivity
184 **- 1 2 3** Acoustic hallucinations
185 **- 1 2 3** Tendency to cry without reason
186 **- 1 2 3** Hair is coarse and/or thinning
187 **- 1 2 3** Weakness
188 **- 1 2 3** Fatigue
189 **- 1 2 3** Skin sensitive to touch
190 **- 1 2 3** Tendency toward hives
191 **- 1 2 3** Nervousness
192 **- 1 2 3** Headache
193 **- 1 2 3** Isomnia
194 **- 1 2 3** Anxiety
195 **- 1 2 3** Anorexia
196 **- 1 2 3** Inability to concentrate; confusion
197 **- 1 2 3** Frequenty stuffy nose; sinus infections
198 **- 1 2 3** Allergy to some foods
199 **- 1 2 3** Loose joints

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
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

231 **- 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 complains 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 of Saliva______________ pH of 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 paitent 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-MENSE FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row.

MALES

Any two days during the month

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue 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:______________
Date:___________	Temperature:______________

BP SIT______________________

PULSE SIT____________________

SALIVA PH___________________

BP STAND_________________

PULSE STAND______________

BLOOD TYPE_______________

CASE RECORD

NAME____________________DATE____________________TELEPHONE____________________

ADDRESS____________________CITY____________________STATE__________ZIP__________

AGE__________WEIGHT__________HEIGHT__________SEX__________

OCCUPATION____________________MARRIED____________________

HISTORY OF ILLNESS AND TREATMENT:____________________

____

OPERATIONS, ACCIDENTS OR INJURIES:____________________

____

PRESENT ILLNESS OR COMPLAINTS:____________________

____

____

DIAGNOSTIC SUMMARY____________________

____

____

TREATMENT, RECOMMENDATIONS AND PROGRESS:____________________

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