INTRODUCTION

Name_____ Home Phone ( )_____ Work Phone ( ) _____
Address_____ City, State_____ Zip _____
Email address_____May I add your email to my mailing list? _____
Age____ Date of Birth_____ Social Sec. # _____ Marital Status M S W D Other
Do you have children? Y N If so, list ages _____
Occupation_____ Employer_____
Work Address _____
Person to contact in case of emergency _____ Phone_____
Who referred you to - or how did you hear about - the office? _____

Please describe the health concern(s) for which you came to our office._____
_____
_____
_____

Have you seen other doctors or health professionals for any of these concerns? Y N
If so, please list professional names and describe treatment(s) and outcome(s)_____
_____
_____
_____

Name of Primary Care Physician_____ Phone_____
Approx. date of most recent blood work_____ Do you have the results? Y N

Have you had ANY serious illnesses, injuries, or hospitalizations? Y N If so, please list below:
Year Illness, Injury, Surgery Hospital, City, State

Please list any conditions or diseases that tend to run in your family and include the blood relationship to you_____
_____

Are you currently taking ANY prescription medications? Y N If so, please list types and dosages if known_____
_____
_____

Do you ever take OTC medications? Y N If so, list type, dosages, and frequency_____

Do you drink alcoholic beverages? Y N If so, please list type and frequency_____
_____

Do you smoke cigarettes or use tobacco products? Y N If so, please describe frequency including # of years

Do you take recreational drugs? Y N If so, please list type(s) and frequency_____

Describe your current diet (i.e. omnivorous, vegetarian, vegan, other)_____
Describe a typical meal_____
In your opinion, is your diet healthy? _____
# of meals/day_____ Do you ever eat fast food? Y N If so, give frequency and describe typical meal ordered_____
Do you drink caffeinated beverages? Y N If so, describe type, frequency, and quantity

Do you snack? Y N If so, list typical snacks and quantity _____

Do you exercise? Y N If so, please list type(s) of activity and frequency_____

Do you currently take any vitamins, herbs, or supplements? Y N If so, please list type and dosages if known

Do you have any known allergy to food, medication, or environmental agent? Y N
If so, please list allergen(s) and describe reaction(s)_____

Have you suffered--past OR present--from any health conditions which have not been covered in this questionnaire? Y N If so, please describe_____

Women Only:
*Are you pregnant or think you could be? Y N Date of last menstrual period*_____
Do you (or have you) experienced PMS, cramps, or heavy periods? Y N If so, please elaborate

All Patients:
I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____
Signature Date

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent ___/___ Standing ___/___ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

1 2 3 **GROUP 7A**

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

GROUP 7B

122 O O O Increase in weight
123 O O O Decrease in appetite
124 O O O Fatigue easily
125 O O O Ringing in ears
126 O O O Sleepy during day
127 O O O Sensitive to cold
128 O O O Dry or scaly skin
129 O O O Constipation
130 O O O Mental sluggishness
131 O O O Hair coarse, falls out
132 O O O Headaches upon arising, wear off during day
133 O O O Slow pulse, below 65
134 O O O Frequency of urination
135 O O O Impaired hearing
136 O O O Reduced initiative

GROUP 7C

137 O O O Failing memory
138 O O O Low blood pressure
139 O O O Increased sex drive
140 O O O Headaches, "splitting or rending" type
141 O O O Decreased sugar tolerance

GROUP 7D

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

GROUP 7E

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

GROUP 7F

157 O O O Weakness, dizziness
158 O O O Chronic fatigue
159 O O O Low blood pressure
160 O O O Nails weak, ridged
161 O O O Tendency to hives
162 O O O Arthritic tendencies
163 O O O Perspiration increase
164 O O O Bowel disorders
165 O O O Poor circulation
166 O O O Swollen ankles
167 O O O Crave salt
168 O O O Brown spots or bronzing of skin
169 O O O Allergies - tendency to asthma

1 2 3

170 O O O Weakness after colds, influenza
171 O O O Exhaustion - muscular and nervous
172 O O O Respiratory disorders

GROUP 8

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

FEMALE ONLY

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

MALE ONLY

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

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

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

Daily Record of Food Intake | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Standard Process®

Name:

Day 1 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Day 2 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Day 3 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Notes:

Day 4 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 5 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 6 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 7 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)