Tanque Verde Chiropractic Cljnic, P.C.
9100 E. Tanque Verde Rd. Suite 140
Tucson, Arizona 85749
Rev 6.2015

Patient No.:_____
Date/Today: _____
Date of Injury:_____ Referred by: _____

PERSONAL INJURY AUTO ACCIDENT CONFIDENTIAL INFORMATION FORM

BIOGRAPHICAL

Name: _____ Social Security No.:_____-_____-_____

Address: _____ Phone:_____

City: _____ Cell/Provider:_____

State/Zip: _____ Email:_____

Employer:_____ Work:_____

Spouse Name: _____ *Phone:*_____

Age:_____ Birth date: ____/____/_____ Sex: __M __F ____ Single ____ Married ____ Divorced ____Separated

Emergency Contact _____
Address: _____ Phone:_____
City/State:_____ Zip:_____

Nearest relative not living with you: _____
Address: _____ Phone:_____
City/State:_____ Zip:_____

HISTORY-Relating to Accident ONLY.

Chief Complaint: _____ Other Complaints:_____

Circle one:

Intensity:	mild	moderate	severe
Nature:	infrequent	occasional	frequent

_____	Headache	_____	Neck pain	_____	Fainting	_____	Loss of smell
_____	Nervousness	_____	Restlessness	_____	Cold feet	_____	Cold hands
_____	Head heavy	_____	Depression	_____	Hearing loss	_____	Loss of strength
_____	Ears buzzing	_____	Balance loss	_____	Blurred vision	_____	Pins/needles-hands
_____	Diarrhea	_____	Constipation	_____	Numbness in toes	_____	Numbness in fingers
_____	Cold sweat	_____	Fever	_____	Back pain	_____	Difficulty swallowing
_____	Double vision	_____	Stiff neck	_____	Insomnia	_____	Fatigue
_____	Chest pain	_____	Dizziness	_____	Face flushed	_____	Pins/needles-legs
_____	Memory loss	_____	Ears ringing	_____	Stomach upset	_____	Lights bother eyes

_____ Other
(explain):_____

List all symptoms present BEFORE the accident:
_____

List all surgeries with dates:_____

_____1. I had no signs or symptoms prior to the accident.
_____2. I had some signs or symptoms prior to the accident, but they are worse/unchanged since the accident.
_____3. Other (explain):_____

Date of last physical exam: _____Doctor: _____ Location: _____

Reason for exam: _____
_____

Patient Name: _____Patient No.:_____

ACCIDENT FACTS: Is there a POLICE REPORT: _____Yes _____No

Who was cited for this accident: _____me _____driver of my vehicle _____other driver _____ no one _____unknown
Did you have warning of this accident? _____yes _____no
You were the _____driver _____passenger _____other (**explain**) _____

If **passenger**, name of driver of vehicle: _____
Name of owner of vehicle:_____

Direction of travel of **your** vehicle: _____north _____south _____east _____west
On which street: _____
Your vehicle was _____going straight _____turning R or L _____stopped _____other (explain) _____

Direction of travel of **other** vehicle: _____north _____south _____east _____west
On which street: _____

Type of collision: _____head-on collision _____broadsided on driver's side _____broadsided on passenger's side
_____I was rear-ended _____Other (explain) _____

Direction of your head during the collision: _____ straight _____ turned right _____turned left
Was your seatbelt worn? _____yes _____no
Did your head or chest hit anything: _____no _____ yes, if **yes**, what? _____
Were you rendered unconscious? _____no _____ yes, if **yes**, how long? _____
My car was: _____ towed _____driven from scene.
Approximate damage to **my** car $ _____ Approximate damage to **other** car $ _____
_____ light _____ moderate _____ severe _____ light _____ moderate _____ severe
Were you transported to a **hospital**? _____yes _____no
If **yes**, which one? _____
If **yes**, how? _____ambulance _____private car
What was done at the hospital: _____exam _____lab work ___x-rays _____ admitted for _____ days
Treatment:_____
_____

Were other doctors seen: _____yes _____ no
If **yes**, who & when? _____

Treatment after the accident: _____rest _____heat _____ice _____non-prescription pain relief (aspirin, etc)
Doctor's prescription: _____muscle relaxants _____pain killers
Other doctor recommendations: _____
Result of treatment: _____ relief _____ no relief _____ uncertain about relief

List symptoms felt immediately after the accident (ex. headaches, sharp pain): _____
_____

Condition since the accident: _____worsening _____no change _____some improvement _____considerable improvement
Number of days **missed** from work due to the accident:_____ **Dates**: _____

List all present medications:_____
Are you allergic to any medication? _____yes _____ no
If **yes**, name medications: _____

Name of **family** Doctor? _____

Do you have an **attorney**? _____yes _____ no

If **yes**, name: _____ phone #:_____

TRUTHFULNESS OF ANSWERS: The above answers are correct to the best of my knowledge.

Date:_____ Patient signature (or guardian):_____

Tanque Verde Chiropractic Clinic, P.C.
Michael Stone, D.C., DABCI
9100 E. Tanque Verde Rd. Suite 140
Tucson, Arizona 85749
520.749.2929 Tel
520.749.8391 Fax
Rev.: 6.2015

AUTO INSURANCE INFORMATION

Patient Name: _____ **Today's Date:** _____

Date of Accident: _____

A. Name of Insurance Co of YOUR car: _____

Address: _____

City: _____ State: _____ Zip_____

Adjustor: _____ Phone:_____

Fax#: _____ Ext.:_____

Name of the Insured: _____

1. Does your coverage include **MedPay**? **Yes** **No** **Unsure**
2. Does your coverage include **Uninsured Motorist**? **Yes** **No** **Unsure**
3. Have you **reported** this accident to YOUR Insurance Co? **Yes** **No** **Unsure**

Your **Claim #**:_____ Your **Policy #**_____

B. Have you retained an ATTORNEY? **Yes** **No**

If yes; Name: _____ Firm: _____

Address: _____

City: _____ State: _____ Zip_____

Phone: _____ Fax#: _____

C. The Other Car—Name of Insurance Co: _____

Name of the Insured: _____ Name of Adjustor: _____

Phone: _____ Fax#: _____

CLAIM #: _____ **Policy #**: _____

Address: _____

City: _____ State: _____ Zip_____

D. Authorization & Assignments of Benefits:

The above answers are correct to the best of my knowledge. I authorize Tanque Verde Chiropractic Clinic, P.C. to release to the appropriate parties information needed for processing of claims or to collect due balances on my account(s).
I also request that all bills be paid upon receipt of each, directly to the provider: Dr. Michael Stone, DABCI.

Patient Signature (or Guardian):_____ Date: _____

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Dr. Michael Stone
Board Certified Chiropractic Internist
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Personal Injury Financial Policy

1. **ATTORNEY**: Please advise us if you have an attorney.

2. **CASH PATIENT**: Regardless of whether or not you have an attorney, if you do not have Med Pay (your Auto Insurance) or a Third Party Liability (person who hit you) you will be considered a **CASH** patient and will be expected to pay for services at the time they are rendered.

3. **PAYMENT**: If the Insurance Company or the Attorney pays you for our services you are expected and required to reimburse the Tanque Verde Chiropractic Clinic, P. C. for services rendered. Please honor the services rendered to you by Dr. Michael Stone.

I have read and agree to the above terms.

Patient Signature Date

Witness Date

Protocol for Preservation of Patient Records

Pursuant to ARS 32-3210 and the requirements of the State of Arizona for the preservation of patient records, this document is intended to inform all patients of Dr. Michael Stone of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. Dr. Stone agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

Dr. Stone will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, Dr. Stone reserves the right to destroy your records. Should Dr. Stone exercise that right, Dr. Stone will first attempt to contact you and inform you of your right to obtain a copy of these records. Dr Stone will attempt to contact you by regular mail, at your last known address, and will give you thirty days (30) days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should Dr. Stone retire, cease to practice, or sell his practice to another health care professional, Dr. Stone will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

By signing I acknowledge receipt of this document.

_____

Patient signature. Date

Acknowledgement and agreement:
Patient's Protocol for Records Preservation

I, _____, patient of Dr. Michael Stone, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform Dr. Stone's office of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address.

_____ _____

Signature of Patient Date

_____

_____

Address

Rev. 6.2015

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Tanque Verde Chiropractic Clinic (TVCC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Tanque Verde Chiropractic Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. TVCC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tanque Verde Chiropractic Clinic.

With my consent, Tanque Verde Chiropractic Clinic may call my home or other designated locations and leave a message on the voice mail or in person in reference to any items that assist in carrying out TPO, such as those involving patient care in any manner, insurance or fee items.

With my consent, Tanque Verde Chiropractic Clinic may mail to my home or other designated locations any items that assist in carrying out TPO, such as letters, patient statements, and records as long as they are marked Personal and Confidential.

With my consent, Tanque Verde Chiropractic Clinic may fax to me or other designated locations any items that assist in carrying out TPO, such as reports, laboratory studies and patient records. I have the right to request that TVCC restrict how it uses or discloses my PHI to carry out TPO. However, the clinic is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to TVCC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that Tanque Verde Chiropractic Clinic has already made disclosures in reliance upon my prior consent. If I do not sign this consent Tanque Verde Chiropractic Clinic may decline to provide treatment to me.

Print Patient name:_____

Patient signature:_____Date:_____

Parent authorization/Legal guardian:_____Date:_____

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Patient Name: _____

Office Policy of Patient Assistance

AUTHORIZATON TO TREAT: I, the undersigned, a patient in this clinic, hereby authorize Dr. Michael Stone, D.C. to examine and administer chiropractic, physiotherapy and acupuncture treatment as he feels necessary and to perform the therapy and manipulations and such additional therapies as he considers therapeutically necessary on the basis of findings during the set course of treatment.

ASSIGNMENT AND AUTHORIZATION FOR INSURANCE OR ATTORNEY TO PAY THE CLINIC DIRECTLY: I authorize the direct payment to the clinic of any sum I now or hereafter owe the clinic by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges of your services.

LIMITED POWER OF ATTORNEY: I, undersigned specifically grant to the clinic a limited power of attorney to act in the undersigned's full place and stead to sign medical insurance claim forms and billings and insurance payment, whether draft or check, for chiropractic care and acupuncture treatment furnished by the clinic to the undersigned. Further, the undersigned herby grants a full assignment of any right, cause or choice of action against any responsible insurance carrier, or for any responsible third party up to the full amount of my bill for chiropractic treatment.

NO PROMISE OF CURE AND POSSIBLE RISKS IF ANY: I hereby certify that I have read and understand the above authorization for chiropractic treatment, and the reasons why the above treatment is indicated, its advantages and possible complications, if any, as well as possible alternative modes of treatment which were explained by the doctor and/or his staff. I also certify that no guarantee or assurance has been made as to the results which I may expect to obtain.

AUTHORIZATON TO RELEASE INFORMATION: I authorize the clinic to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collections under this agreement. I agree that this agreement is non-revocable.

TANQUE VERDE CHIROPRACTICE CLINIC WILL CHARGE FOR MISSED APPOINTMENTS: $40.00

I understand that I will be charged for missed appointments: _____
Patient Initials

Patient's Signature: _____ **Date**_____

Witness: _____ **Date**_____

Parent or Guardian: _____ **Date**_____
(if patient is a minor)

ATTORNEY AGREEMENT: The undersigned, being the attorney of record for the above signed patient, hereby agrees to observe all the terms above and agree to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the doctor and clinic immediately upon settlement or verdict upon the case. It is further agreed, the undersigned, will contact the clinic to verify amounts owed to the clinic for services rendered to the above signed patient before settlement or disbursement of funds.

Attorney's Signature: _____ **Date**_____

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Acknowledgement of Responsibility for Uncovered Services

It is hereby acknowledged, by the undersigned, that certain services may not be covered by any insurance, including but not limited to, medical payments coverage, health insurance, and/or Medicare.

If an insurance company determines that they are not responsible for a particular service; that it is either not necessary or not covered for any other reason, and therefore, denies payment, I hereby acknowledge that I am personally responsible for payment of these services.

I acknowledge that my doctor will determine whether or not the services are medically necessary and agree to pay for the service for these services, whether they are covered or not.

I agree to make arrangements with the doctor's office to pay for the services as they are provided to me.

Dated: _____

Patient Print Name: _____

Patient Signature: _____

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Auto Accident Paperwork Required by TVCC

In order for us to properly assist you with your Auto Accident we need the following paperwork:

Copy of Patient Auto Insurance Card

Copy of Declaration Page of Patients Auto Insurance

Copy of Patients Driver's License

Copy of Health Insurance Card

Copy of Accident Report

MUST HAVE: Claim Number

MUST HAVE if Patient has contacted Attorney—Attorney's name, address, telephone, fax

Rev.: 6.2015

Systems Survey Form | Restricted to Professional Use

Standard Process

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

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 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

___ ___ ___ TOTAL

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

___ ___ ___ TOTAL

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

___ ___ ___ TOTAL

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

___ ___ ___ TOTAL

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

___ ___ ___ TOTAL

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

___ ___ ___ TOTAL

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

___ ___ ___ TOTAL

GROUP 7B

119. 1 2 3 Increase in weight
120. 1 2 3 Decrease in appetite
121. 1 2 3 Fatigue easily
122. 1 2 3 Ringing in ears
123. 1 2 3 Sleepy during day
124. 1 2 3 Sensitive to cold
125. 1 2 3 Dry or scaly skin
126. 1 2 3 Temporary constipation
127. 1 2 3 Mental sluggishness
128. 1 2 3 Hair coarse, falls out
129. 1 2 3 Tension in head upon arising wears off during day
130. 1 2 3 Slow pulse below 65
131. 1 2 3 Changing urinary function
132. 1 2 3 Sounds appear diminished
133. 1 2 3 Reduced initiative

___ ___ ___ TOTAL

GROUP 7C

134. 1 2 3 Failing memory with age
135. 1 2 3 Increased sex drive
136. 1 2 3 Episodes of tension in head
137. 1 2 3 Decreased sugar tolerance

___ ___ ___ TOTAL

GROUP 7D

138. 1 2 3 Abnormal thirst
139. 1 2 3 Bloating of abdomen
140. 1 2 3 Weight gain around hips or waist
141. 1 2 3 Sex drive reduced or lacking
142. 1 2 3 Tendency for stomach issues
143. 1 2 3 Immune system challenges
144. 1 2 3 Menstrual disorders

___ ___ ___ TOTAL

GROUP 7E

145. 1 2 3 Dizziness
146. 1 2 3 Headaches
147. 1 2 3 Hot flashes
148. 1 2 3 Hair growth on face or body (female)
149. 1 2 3 Sugar in urine (not diabetes)
150. 1 2 3 Masculine tendencies (female)

___ ___ ___ TOTAL

GROUP 7F

151. 1 2 3 Weakness, dizziness
152. 1 2 3 Tired throughout day
153. 1 2 3 Nails weak, ridged
154. 1 2 3 Sensitive skin
155. 1 2 3 Stiff joints
156. 1 2 3 Perspiration increase
157. 1 2 3 Bowel discomfort
158. 1 2 3 Poor circulation
159. 1 2 3 Swollen ankles
160. 1 2 3 Crave salt
161. 1 2 3 Areas of skin darkening
162. 1 2 3 Upper respiratory sensitivity
163. 1 2 3 Tiredness
164. 1 2 3 Breathing challenges

___ ___ ___ TOTAL

GROUP 8

165. 1 2 3 Muscle weakness
166. 1 2 3 Lack of stamina
167. 1 2 3 Drowsiness after eating
168. 1 2 3 Muscular soreness
169. 1 2 3 Heart races
170. 1 2 3 Hyperirritable
171. 1 2 3 Feeling of a band around head
172. 1 2 3 Melancholia (feeling of sadness)
173. 1 2 3 Swelling of ankles
174. 1 2 3 Change in urinary function
175. 1 2 3 Tendency to consume sweets/carbohydrates
176. 1 2 3 Muscle spasms
177. 1 2 3 Blurred vision
178. 1 2 3 Involuntary muscle action
179. 1 2 3 Numbness
180. 1 2 3 Night sweats
181. 1 2 3 Rapid digestion
182. 1 2 3 Sensitivity to noise
183. 1 2 3 Redness of palms of hands and bottom of feet
184. 1 2 3 Visible veins on chest and abdomen
185. 1 2 3 Hemorrhoids
186. 1 2 3 Apprehension (feeling that something bad is going to happen)
187. 1 2 3 Nervousness causing loss of appetite
188. 1 2 3 Nervousness with indigestion
189. 1 2 3 Gastritis
190. 1 2 3 Forgetfulness
191. 1 2 3 Thinning hair

___ ___ ___ TOTAL

FEMALE ONLY

192. 1 2 3 Very easily fatigued
193. 1 2 3 Premenstrual tension
194. 1 2 3 Menses more painful than usual
195. 1 2 3 Depressed feelings before menstruation
196. 1 2 3 Painful breasts during menses
197. 1 2 3 Menstruate too frequently
198. 1 2 3 Hysterectomy/ovaries removed
199. 1 2 3 Menopausal hot flashes
200. 1 2 3 Menses scanty or missed
201. 1 2 3 Acne, worse at menses

___ ___ ___ TOTAL

MALE ONLY

202. 1 2 3 Less involved in exercise/social activities
203. 1 2 3 Difficult to postpone urination
204. 1 2 3 Weak urinary stream
205. 1 2 3 Feeling of "blues" or melancholy
206. 1 2 3 Feeling of incomplete bowel evacuation
207. 1 2 3 Lack of energy
208. 1 2 3 Muscles in arms and legs seem softer/smaller
209. 1 2 3 Tire too easily
210. 1 2 3 Avoid activity
211. 1 2 3 Leg nervousness at night
212. 1 2 3 Diminished sex drive

___ ___ ___ TOTAL

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

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

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion
_____ Hydrochloric Acid Point
_____ Enzyme Point
_____ Murphy's Sign

Large Intestine (Palpate)
_____ Ascending
_____ Transverse
_____ Descending

Adrenals
Pass/Fail Pupil Dilation Exam
Postural Hypotension
_____ Supine
_____ Standing

Pass/Fail Zinc Taste Test
Pass/Fail Cuff Test
_____ Cuff Pressure
_____ pH of Saliva
_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning 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 such as 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 (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.