A.K. CHIROPRACTIC CENTER

1276 JUNGERMANN ROAD

ST. PETERS, MO 63376

(636)922-9993 FAX(636)922-9994

OFFICE AND FINANCIAL POLICY

Our office is committed to your health and well-being. Because of this commitment, we are a medium volume practice. We like to spend the time with you that we feel you need. Usually, the minimum time spent per visit is 30 minutes. Our prices therefore reflect the time spent under care. It is our policy to explain all procedures and fees. It is our intention that you are fully educated every step of the way.

Our charges are as follows:	Initial Visit :	$120.00
	1 Hour Visit:	$120.00
	½ Hour Visit:	$ 60.00
	Microscope Visit:	$ 35.00
	Allergy De-sensitization:	$ 10.00
	After Hours Minimum:	$120.00

Transfer and Cancelation Policy:
If you cannot keep an appointment, we ask that you call our office and notify us as soon as possible. This courtesy on your part makes it possible to give an appointment to another patient who desires to see the doctor. There is no charge for rescheduling or canceling an appointment as long as it is done at least 12 hours prior to the scheduled appointment time. Failure to transfer or cancel your appointment prior to 12 hours will result in a $40.00 missed appointment fee.

Appointment Scheduling:
Our office works by scheduled appointment only. Please try to understand though that if you are late to your appointment then our schedule will run late from that point forward. Therefore, if you arrive late to an appointment we cannot guarantee that you will be able to be treated that day or that you will have the full time allotted for your treatment.

HIPAA Policy:
At the A.K. Chiropractic Center, we are committed to treating and using protected health information about you responsibly. The Notice of Privacy Practices describes the personal information we collect, and how we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective November 10, 2010, and applies to all protected health information as defined by federal regulators. Should you have questions or require additional information, you may contact the Privacy Officer Patricia Schiermeyer at (636) 922-9993.

A K CHIROPRACTIC CENTER

PATIENT INFORMATION

Patient First Name:_____ M.I.:_____ Last Name:_____

Address:_____City:_____

State:_____Zip:_____ E-Mail: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date:_____ Social Security #:_____ Sex: M / F

Spouse's First Name: _____ M.I.:_____ Last Name:_____

Spouse's Social Security: _____ Birth Date: _____

CURRENT HEALTH CONDITION

Purpose of this appointment_____

Other Doctors seen for this condition?_____ Who?_____

Type of Treatment: _____ Results?_____

When did this condition begin?_____ Has this condition Occurred before? Y / N

Is your problem related to an injury?

□ Yes □ No ❑ Car ❑ Accident ❑ Slip/Fall ❑ Work Related ❑ Other

If other, please describe:_____

Drugs you now take: _____

Do you wear a shoe lift? Y / N

Do you suffer from any condition other than that which you are now consulting us?

_____

_____

PAST HEALTH HISTORY

Please check and describe:

□ Major Surgery □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia
□ Back Surgery □ Broken Bones □ Other

Major Accident or Falls: _____

Hospitalization (Other than above):_____

HOW WERE YOU REFERRED?

How were you referred?

□ Internet/website □ Google □ Health Presentation □ Yellow Pages □ Other
□ Referred by:_____

IF THIS IS DUE TO AN AUTOMOBILE ACCIDENT OR A WORKERS COMPENSATION CLAIM,

PLEASE LET THE FRONT DESK PERSON KNOW THAT! THANK YOU

NAME:_____

A K CHIROPRACTIC CENTER

PATIENT CONFIDENTIAL HEALTH HISTORY

Please check if any of these apply to you.

GENERAL

1 ___ Fever
2 ___ Chills
3 ___ Night Sweats
4 ___ Loss of Sleep
5 ___ Fatigue
6 ___ Nervousness
7 ___ Weight Loss or Gain
8 ___ Allergies
9 ___ Bleeding Problems
10 ___ Anemia
11 ___ Diabetes
12 ___ Cancer
13 ___ Thyroid Disease/Goiter
14 ___ Alcoholism
15 ___ Drug Abuse

EAR, EYE, NOSE, THROAT

16 ___ Poor Vision
17 ___ Pain in Eye(s)
18 ___ Deafness/Difficulty Hearing
19 ___ Nosebleeds
20 ___ Nose Problems
21 ___ Sinus Trouble
22 ___ Dental Problems
23 ___ Hoarseness
24 ___ Tonsillectomy

GASTROINTESTINAL

25 ___ Poor Appetite
26 ___ Poor Digestion
27 ___ Difficulty Swallowing
28 ___ Belching or Gas
29 ___ Frequent Nausea
30 ___ Vomiting
31 ___ Vomiting Blood
32 ___ Pain over Abdomen
33 ___ Ulcer
34 ___ Black or Bloody Stools
35 ___ Liver Problems
36 ___ Gall Bladder Problems
37 ___ Jaundice
38 ___ Hernia
39 ___ Diarrhea
40 ___ Constipation
41 ___ Hemorrhoids
42 ___ Appendicitis

MEN ONLY

43 ___ Testicular Swelling/Pain
44 ___ Prostate Problems

RESPIRATORY

45 ___ Difficulty in Breathing
46 ___ Chroinic Cough
47 ___ Spitting Phelgm
48 ___ Spitting Blood
49 ___ Wheezing/Asthma
50 ___ Pneumonia
51 ___ Tuerculosis

CARDIOVASCULAR

52 ___ Irregular Heartbeat
53 ___ High Blood Pressure
54 ___ Pain Over Heart
55 ___ Previous Heart Trouble
56 ___ Ankle Swelling
57 ___ Varicose Veins
58 ___ Rheumatic Fever
59 ___ Stroke

GENITOURINARY

60 ___ Frequent Urination
61 ___ Painful Urination
62 ___ Blood in Urine
63 ___ Kidney Disease
64 ___ Urinary Infection
65 ___ Inabiity to Control Urination
66 ___ Difficulty Starting Urine Flow
67 ___ Get Up at Night to Urinate
68 ___ Breast Lump or Pain
69 ___ Veneral Infection
70 ___ Sexual Difficulties

SKIN

71 ___ Itching
72 ___ Bruising Easily
73 ___ Change in Mole(s)
74 ___ Skin Cancer
75 ___ Scars Location

NEUROLOGIC

76 ___ Weakness
77 ___ Twitching
78 ___ Tremors
79 ___ Headache
80 ___ Fainting
81 ___ Dzziness
82 ___ Convulsions
83 ___ Epilepsy/Seizures
84 ___ Numbing/Tingling
85 ___ Arm/Leg Pain
86 ___ Mental Disorder

MUSCULOSKELETAL

87 ___ Neck Stiffness/Pain
88 ___ Pain Between Shoulders
89 ___ Low Back Pain
90 ___ Swollen Joints
91 ___ Painful Joints
92 ___ Muscle Aches/Soreness
93 ___ Spinal Curvature
94 ___ Arthritis

WOMEN ONLY

95 ___ Painful Periods
96 ___ Excessive Flow
97 ___ Irregular Cycles
98 ___ Vaginal Burning/Itching
99 ___ Hot Flashes
100 ___ Date Last Period Began:
101 ___ Date of Last Pap Smear:

EXERCISE

102 ___ None
103 ___ 1 - 2 times/week
104 ___ 3 - 5 times/week
105 ___ 6 - 7 times/week

HABITS

106 ___ Smoking ___# packs/day
107 ___ Drinking
108 ___ Recreational Drug Use
109 ___ Caffeine

FAMILY HISTORY
DO NOT INCLUDE YOURSELF

Include information on brothers, sisters parents and grandparents.

110 ___ Diabetes
111 ___ Thyroid Disease/Goiter
112 ___ Tuberculosis
113 ___ Kidney Disease
114 ___ High Blood Pressure
115 ___ Heart Disease
116 ___ Cancer
117 ___ Muscle,Bone or Nerve Disease
118 ___ Lung Disease
119 ___ Ulcers
120 ___ Arthritis
121 ___ Seizures/Strokes

MISCELLANEOUS

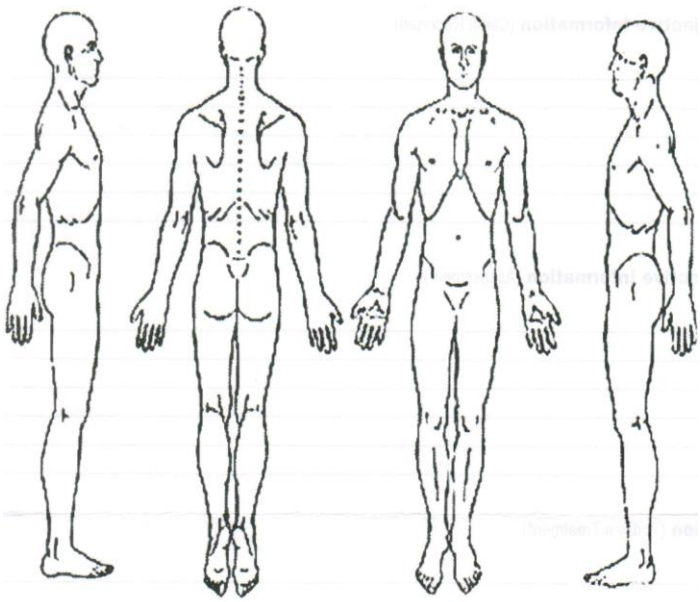
A K CHIROPRATIC CENTER

PATIENT INFORMATION

SYMPTOMS **NAME:**_____

If you are in pain, please mark the exact location of your pain on the diagram below, using the following letters to indicate the type of pain.

D = DULL	**T = TINGLING**	**B = BURNING**
S = SHARP	**N = NUMBING**	**TH = THROBBING**



Severe Pain

Moderate Pain →

No Pain

Frequency of pain:

□ Constant □ Frequent □ Intermittent □ Occasional

Aggravated by:

□ Lying □ Sitting □ Standing □ Bending
□ Coughing □ Movement

Duration:

□ Days □ Weeks □ Months □ Years

Comments:

_____
_____
_____

CONSENT TO CHIROPRACTIC TREATMENT

The Material Risk Inherent To Your Treatment
Chiropractic care is a safe and effective approach for many health conditions, however as with any health care procedures, chiropractic treatments present the risks of complication or negative side effects. The list below includes the various treatments available in our clinic and the potential risks associated with these treatments.

Chiropractic Manipulation Therapy
The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment.

Soft Tissue Technique
A ceramic instrument is used to strip a muscle or tendon, softening adhesions and promoting healing of the injured or scarred tissue. In some instances this procedure may cause bruising and some reactive swelling. This may be uncomfortable but is not creating any harm to the patient and this reaction is part of the healing process. Please inform the doctor if you are taking a blood thinner medication or if you bruise easily.

Laboratory Tests
Laboratory tests, including the collection of a blood sample may be ordered to help you diagnose your condition. Some patients may faint at the sight of needles or blood. Patients with delicate veins may experience some bruising at the skin puncture site. In very rare instances the needle can touch a nerve, causing pain for a few days or a few weeks.

Decompression Therapy
Most patients do not experience any adverse side effects from undergoing Non-Surgical Spinal Decompression Therapy. Occasionally, a few patients experience muscle spasm for a limited time.

Do Not Sign Until You Have Read And Understand The Above.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the A.K. Chiropractic Doctors or Staff and have had my questions answered to my satisfaction.
By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or, in the case of minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ Dated: _____
Patient's Name

_____
Patient's Signature Or Guardian/Parent Signature if minor

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PAYMENT RESPONSIBILITY

Patient Information:

As a **'*cash/self*'** patient, I understand I will be provided with superbills or detailed statements indicating the diagnosis and procedure codes and receipts for services rendered. I understand the physician will not bill any third party payers on my behalf. I accept any and all responsibilities and liabilities of submitting my own documentation and claims for reimbursement from any and all insurance companies or third party complications that may arise in my attempts to receive compensation from any third party payer.

Personal Injury or Automobile Accidents:

I hereby authorize and direct my attorney and/or insurance company, to **pay directly to A.K. Chiropractic Center P.C.** Such sums as may be due and owing **A.K. Chiropractic Center P.C.** for professional services rendered me both by reason of this illness or accident and by reason of any other bills that are due his office.

I hereby authorize **A.K. Chiropractic Center** P.C to furnish my attorney and/or insurance company, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the illness or injury in which I was involved.

I fully understand that I am directly and *fully responsible* to A.K. Chiropractic Center P.C. for all medical bills submitted for services rendered. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover fees.

Patient's signature_____ Date_____

Print patient's name_____DOB:_____

SYSTEMS SURVEY FORM
(Restricted to Professional Use)

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 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, asthma, bronchitis

GROUP THREE

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

GROUP FOUR

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

GROUP FIVE

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

GROUP SIX

98 - 1 2 3 Loss of taste for meat
99 - 1 2 3 Lower bowel gas several hours after eating
100 - 1 2 3 Burning stomach sensations, eating relieves
101 - 1 2 3 Coated tongue
102 - 1 2 3 Pass large amounts of foul-smelling gas
103 - 1 2 3 Indigestion ½ - 1 hour after eating; may be up to 3 – 4 hrs.
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 Insomnia
108 - 1 2 3 Nervousness
109 - 1 2 3 Can't gain weight
110 - 1 2 3 Intolerance to heat
111 - 1 2 3 Highly emotional
112 - 1 2 3 Flush easily
113 - 1 2 3 Night sweats
114 - 1 2 3 Thin, moist skin
115 - 1 2 3 Inward trembling
116 - 1 2 3 Heart palpitates
117 - 1 2 3 Increased appetite without weight gain
118 - 1 2 3 Pulse fast at rest
119 - 1 2 3 Eyelids and face twitch
120 - 1 2 3 Irritable and restless
121 - 1 2 3 Can't work under pressure

(B)

122 - 1 2 3 Increase in weight
123 - 1 2 3 Decrease in appetite
124 - 1 2 3 Fatigue easily
125 - 1 2 3 Ringing in ears
126 - 1 2 3 Sleepy during day
127 - 1 2 3 Sensitive to cold
128 - 1 2 3 Dry or scaly skin
129 - 1 2 3 Constipation
130 - 1 2 3 Mental sluggishness
131 - 1 2 3 Hair coarse, falls out
132 - 1 2 3 Headaches upon arising wear off during day
133 - 1 2 3 Slow pulse, below 65
134 - 1 2 3 Frequency of urination
135 - 1 2 3 Impaired hearing
136 - 1 2 3 Reduced initiative

(C)

137 - 1 2 3 Failing memory
138 - 1 2 3 Low blood pressure
139 - 1 2 3 Increased sex drive
140 - 1 2 3 Headaches, "splitting or 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 menstrual function

(E)

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

(F)

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

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 Forgetfulness
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 Insomnia
194 - 1 2 3 Anxiety
195 - 1 2 3 Anorexia
196 - 1 2 3 Inability to concentrate; confusion
197 - 1 2 3 Frequent 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

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

IMPORTANT

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

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

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent_____ Standing_____ Pulse_____

Hema-Combistix Urine readings: pH_____ Albumin per cent_____ Glucose per cent_____

Occult Blood_____ pH 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 patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
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 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____

BP SIT_____ BP STAND_____
PULSE SIT_____ PULSE STAND_____
SALIVA PH_____ BLOOD TYPE_____