
A.K. CHIROPRACTIC CENTER

1 2 7 6 J U N G E R M A N N R O A D

S T . P E T E R S , M O 6 3 3 7 6

(6 3 6) 9 2 2 - 9 9 9 3 F A X (6 3 6) 9 2 2 - 9 9 9 4

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 (90 minutes):	\$90.00
	Minimum 1 Hour Visit:	\$60.00
	Every additional 30 minutes	\$30.00
	After Hours Minimum/Hr:	\$100.00

Transfer and Cancellation 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**

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 Chronic Cough
 47 Spitting Phlegm
 48 Spitting Blood
 49 Wheezing/Asthma
 50 Pneumonia
 51 Tuberculosis

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 Inability to Control Urination
 66 Difficulty Starting Urine Flow
 67 Get Up at Night to Urinate
 68 Breast Lump or Pain
 69 Venereal 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 Dizziness
 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/Stroke

MISCELLANEOUS

A K CHIROPRACTIC 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

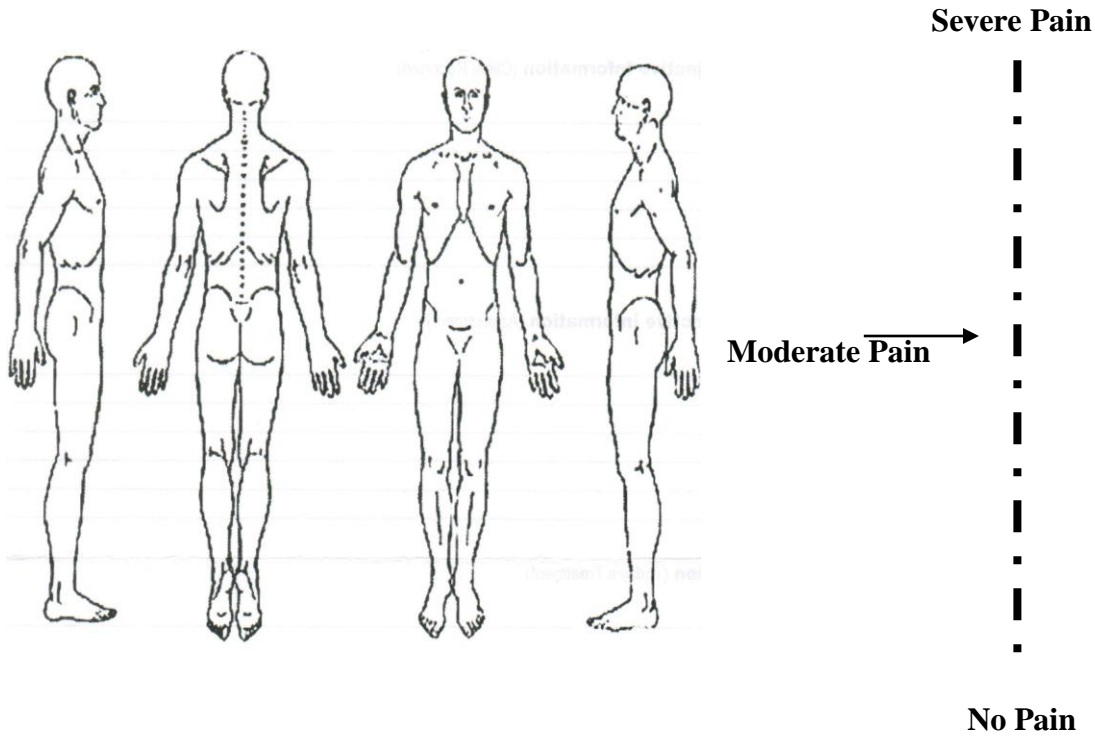
T = TINGLING

B = BURNING

S = SHARP

N = NUMBING

TH = THROBBING



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 | 8 - 1 2 3 Gag easily | 15 - 1 2 3 Appetite reduced |
| 2 - 1 2 3 Get chilled, often | 9 - 1 2 3 Unable to relax; startles easily | 16 - 1 2 3 Cold sweats often |
| 3 - 1 2 3 "Lump" in throat | 10 - 1 2 3 Extremities cold, clammy | 17 - 1 2 3 Fever easily raised |
| 4 - 1 2 3 Dry mouth-eyes-nose | 11 - 1 2 3 Strong light irritates | 18 - 1 2 3 Neuralgia-like pains |
| 5 - 1 2 3 Pulse speeds after meal | 12 - 1 2 3 Urine amount reduced | 19 - 1 2 3 Staring, blinks little |
| 6 - 1 2 3 Keyed up - fail to calm | 13 - 1 2 3 Heart pounds after retiring | 20 - 1 2 3 Sour stomach frequent |
| 7 - 1 2 3 Cuts heal slowly | 14 - 1 2 3 "Nervous" stomach | |

GROUP TWO

- | | | |
|---|---|---|
| 21 - 1 2 3 Joint stiffness after arising | 29 - 1 2 3 Digestion rapid | 37 - 1 2 3 "Slow starter" |
| 22 - 1 2 3 Muscle-leg-toe cramps at night | 30 - 1 2 3 Vomiting frequent | 38 - 1 2 3 Get "chilled" infrequently |
| 23 - 1 2 3 "Butterfly" stomach, cramps | 31 - 1 2 3 Hoarseness frequent | 39 - 1 2 3 Perspire easily |
| 24 - 1 2 3 Eyes or nose watery | 32 - 1 2 3 Breathing irregular | 40 - 1 2 3 Circulation poor, sensitive to cold |
| 25 - 1 2 3 Eyes blink often | 33 - 1 2 3 Pulse slow; feels "irregular" | 41 - 1 2 3 Subject to colds, asthma, bronchitis |
| 26 - 1 2 3 Eyelids swollen, puffy | 34 - 1 2 3 Gagging reflex slow | |
| 27 - 1 2 3 Indigestion soon after meals | 35 - 1 2 3 Difficulty swallowing | |
| 28 - 1 2 3 Always seems hungry; feels "lightheaded" often | 36 - 1 2 3 Constipation, diarrhea alternating | |

GROUP THREE

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

GROUP FOUR

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

GROUP FIVE

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

GROUP SIX

- | | | | | | |
|-------------|---|-------------|--|-------------|-------------------------------------|
| 98 - 1 2 3 | Loss of taste for meat | 101 - 1 2 3 | Coated tongue | 104 - 1 2 3 | Mucous colitis or "irritable bowel" |
| 99 - 1 2 3 | Lower bowel gas several hours after eating | 102 - 1 2 3 | Pass large amounts of foul-smelling gas | 105 - 1 2 3 | Gas shortly after eating |
| 100 - 1 2 3 | Burning stomach sensations, eating relieves | 103 - 1 2 3 | Indigestion ½ - 1 hour after eating; may be up to 3 - 4 hrs. | 106 - 1 2 3 | Stomach "bloating" after eating |

GROUP SEVEN

- | | | | | | |
|-------------|--|-------------|---|-------------|--------------------------------------|
| (A) | | | | (E) | |
| 107 - 1 2 3 | Insomnia | | | 150 - 1 2 3 | Dizziness |
| 108 - 1 2 3 | Nervousness | | | 151 - 1 2 3 | Headaches |
| 109 - 1 2 3 | Can't gain weight | | | 152 - 1 2 3 | Hot flashes |
| 110 - 1 2 3 | Intolerance to heat | | | 153 - 1 2 3 | Increased blood pressure |
| 111 - 1 2 3 | Highly emotional | | | 154 - 1 2 3 | Hair growth on face or body (female) |
| 112 - 1 2 3 | Flush easily | | | 155 - 1 2 3 | Sugar in urine (not diabetes) |
| 113 - 1 2 3 | Night sweats | (C) | | 156 - 1 2 3 | Masculine tendencies (female) |
| 114 - 1 2 3 | Thin, moist skin | 137 - 1 2 3 | Failing memory | | |
| 115 - 1 2 3 | Inward trembling | 138 - 1 2 3 | Low blood pressure | (F) | |
| 116 - 1 2 3 | Heart palpitates | 139 - 1 2 3 | Increased sex drive | 157 - 1 2 3 | Weakness, dizziness |
| 117 - 1 2 3 | Increased appetite without weight gain | 140 - 1 2 3 | Headaches, "splitting or rending" type | 158 - 1 2 3 | Chronic fatigue |
| 118 - 1 2 3 | Pulse fast at rest | 141 - 1 2 3 | Decreased sugar tolerance | 159 - 1 2 3 | Low blood pressure |
| 119 - 1 2 3 | Eyelids and face twitch | | | 160 - 1 2 3 | Nails weak, ridged |
| 120 - 1 2 3 | Irritable and restless | (D) | | 161 - 1 2 3 | Tendency to hives |
| 121 - 1 2 3 | Can't work under pressure | 142 - 1 2 3 | Abnormal thirst | 162 - 1 2 3 | Arthritic tendencies |
| (B) | | 143 - 1 2 3 | Bloating of abdomen | 163 - 1 2 3 | Perspiration increase |
| 122 - 1 2 3 | Increase in weight | 144 - 1 2 3 | Weight gain around hips or waist | 164 - 1 2 3 | Bowel disorders |
| 123 - 1 2 3 | Decrease in appetite | 145 - 1 2 3 | Sex drive reduced or lacking | 165 - 1 2 3 | Poor circulation |
| 124 - 1 2 3 | Fatigue easily | 146 - 1 2 3 | Tendency to ulcers, colitis | 166 - 1 2 3 | Swollen ankles |
| 125 - 1 2 3 | Ringing in ears | 147 - 1 2 3 | Increased sugar tolerance | 167 - 1 2 3 | Crave salt |
| 126 - 1 2 3 | Sleepy during day | 148 - 1 2 3 | Women: menstrual disorders | 168 - 1 2 3 | Brown spots or bronzing of skin |
| 127 - 1 2 3 | Sensitive to cold | 149 - 1 2 3 | Young girls: lack of menstrual function | 169 - 1 2 3 | Allergies – tendency to asthma |
| 128 - 1 2 3 | Dry or scaly skin | | | 170 - 1 2 3 | Weakness after colds, influenza |
| 129 - 1 2 3 | Constipation | | | 171 - 1 2 3 | Exhaustion – muscular and nervous |
| 130 - 1 2 3 | Mental sluggishness | | | 172 - 1 2 3 | Respiratory disorders |
| 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 | | | | |

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 - 1 2 3 Apprehension	200 - 1 2 3 Very easily fatigued	213 - 1 2 3 Prostate trouble
174 - 1 2 3 Irritability	201 - 1 2 3 Premenstrual tension	214 - 1 2 3 Urination difficult or dribbling
175 - 1 2 3 Morbid fears	202 - 1 2 3 Painful menses	215 - 1 2 3 Night urination frequent
176 - 1 2 3 Never seems to get well	203 - 1 2 3 Depressed feelings	216 - 1 2 3 Depression
177 - 1 2 3 Forgetfulness	204 - 1 2 3 Menstruation excessive and prolonged	217 - 1 2 3 Pain on inside of legs or heels
178 - 1 2 3 Indigestion	205 - 1 2 3 Painful breasts	218 - 1 2 3 Feeling of incomplete bowel evacuation
179 - 1 2 3 Poor appetite	206 - 1 2 3 Menstruate too frequently	219 - 1 2 3 Lack of energy
180 - 1 2 3 Craving for sweets	207 - 1 2 3 Vaginal discharge	220 - 1 2 3 Migrating aches and pains
181 - 1 2 3 Muscular soreness	208 - 1 2 3 Hysterectomy/ovaries removed	221 - 1 2 3 Tire too easily
182 - 1 2 3 Depression; feelings of dread	209 - 1 2 3 Menopausal hot flashes	222 - 1 2 3 Avoids activity
183 - 1 2 3 Noise sensitivity	210 - 1 2 3 Menses scanty or missed	223 - 1 2 3 Leg nervousness at night
184 - 1 2 3 Acoustic hallucinations	211 - 1 2 3 Acne, worse at menses	224 - 1 2 3 Diminished sex drive
185 - 1 2 3 Tendency to cry without reason	212 - 1 2 3 Depression of long standing	
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		

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 _____

PULSE SIT _____

SALIVA PH _____

BP STAND _____

PULSE STAND _____

BLOOD TYPE _____