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# A.K. CHIROPRACTIC CENTER

2061 COLLIER CORPORATE PARKWAY

ST. CHARLES, MO 63303

PH:(636)724-5058 FAX:(636)724-5230

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## 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. 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.

Dr. Jeremy Schiermeyer Initial Visit:	\$190.00
1 Hour Visit:	\$190.00
½ Hour Visit:	\$95.00
Acupuncture:	\$95.00

Dr. Candice Mathis Initial Visit:	\$100.00
Follow Up Visit:	\$50.00
1st Acupuncture Visit:	\$100.00
Acupuncture FollowUp:	\$50.00

Dr. Erin Hogan Initial Visit:	\$130.00
1 Hour Visit:	\$130.00
½ Hour Visit:	\$65.00

### Additional Services:

Laser therapy in office:	\$30.00
At Home Laser Therapy	\$65- \$80
Laser Vials:	\$120.00

Heart Graph:	\$25.00
Bio-Health Scans:	\$150.00
SAAT:	\$120.00

### Appointment Scheduling:

Our office works by scheduled appointment only. Please try to understand that if you are late to your appointment then our schedule will run late from that point forward. Therefore, please be considerate and arrive a few minutes before your scheduled appointment. We sincerely apologize if our office is running behind schedule. If deemed necessary by the doctor/staff a patient may require to book future appointments at a full hour at the rate listed above.

### 1<sup>st</sup> Visit/Appointment:

The times & prices listed above are subject to change. The 1st Time Patient Deposit of \$190.00 will hold the allotted time for your visit, and is designated for **you only**. Please schedule spouse/children/parents/friends their own separate appointments. You will be charged per patient treated/consulted, not per appointment slot time. We do this in order to make sure patients get the full attention and care needed and to keep our office running on time. **Deposit can only be applied to 1<sup>st</sup> appointment with the doctor**, no other services or products. Charges for visits do not include additional costs of supplements, equipment rentals, laboratory testing, or other therapies. Additional time in the office might also be needed for in office scans, testing, therapies, etc.

As a patient, I understand payment is due at the time of service. We ask that you call our office and notify us as soon as possible if you cannot make an appointment. There is no charge for rescheduling or canceling an appointment as long as it is done at least 48 hours prior to the appointment time. **Failure to reschedule or cancel your appointment prior to 48 hours will result in: New Patients losing the full deposit of \$190 or Existing Patients will be charged a missed appointment fee of \$50.00.**

### 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) 724-5058.

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**A.K. CHIROPRACTIC CENTER**  
*PATIENT INFORMATION*

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First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: M / F Referred by: \_\_\_\_\_

Spouse's Or Guardian's (if under 18) First/Last Name: \_\_\_\_\_

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**CURRENT HEALTH CONDITION**

Purpose of doctor's visit: \_\_\_\_\_

Other Treatments tried for this condition? \_\_\_\_\_

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

Do you adhere to a special diet?: \_\_\_\_\_

Please list Any & All Health Conditions: \_\_\_\_\_

Prescriptions/Supplements you take: \_\_\_\_\_

Major Hospitalization/Surgeries/Procedures /Accidents/Falls: \_\_\_\_\_

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**PAYMENT RESPONSIBILITY / CANCELTION POLICY:**

● As a patient, I understand payment is **due at the time of service.** **Patient Initials:** \_\_\_\_\_

● We ask that you call our office and notify us as soon as possible if you cannot make an appointment. There is no charge for rescheduling or canceling an appointment as long as it is done at least 48 hours prior to the appointment time. Failure to cancel or reschedule your appointment prior to 48 hours will result in: New Patients losing \$190.00 deposit, Existing patients will be charged a missed appointment fee of \$50.00. **Patient Initials:** \_\_\_\_\_

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  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

**GENTOURINARY**

- 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/-strokes

**MISCELLANEOUS**

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**A K CHIROPRACTIC CENTER**  
**PATIENT INFORMATION**

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**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**

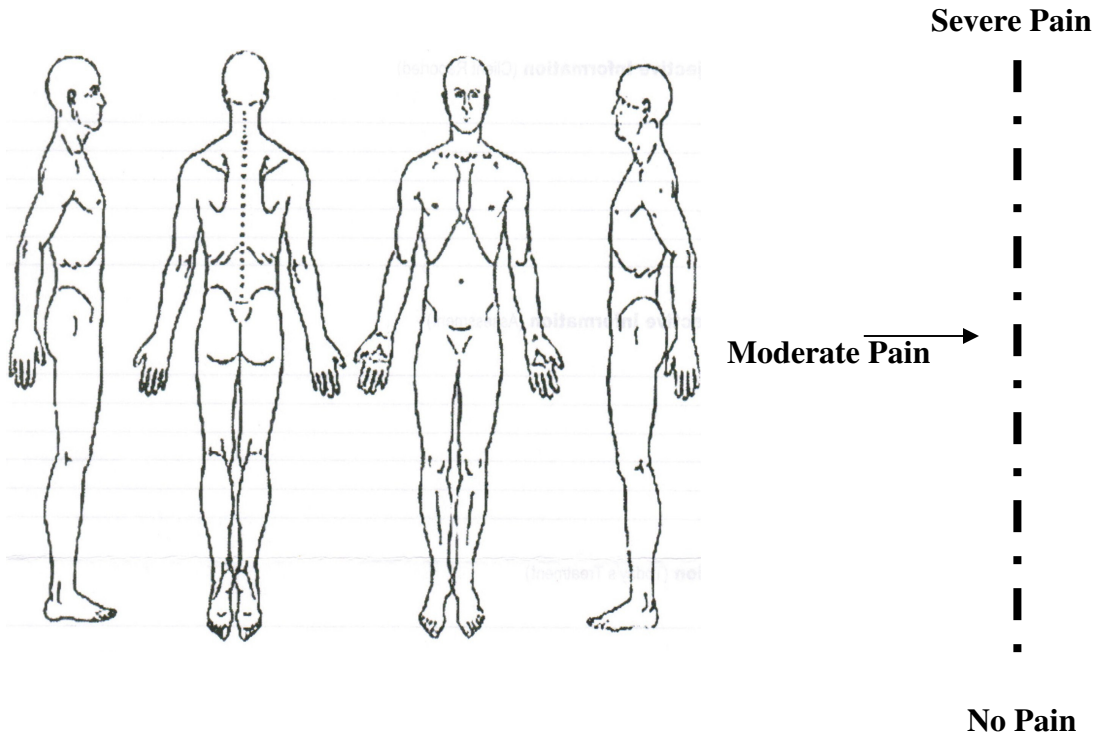
**T = TINGLING**

**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:**

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# 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 diagnose your condition. Some patients may faint at the sight of needles or blood. Patients with delicate veins may experience some bruising at the puncture site. In very rare instances, the needle can touch a nerve, causing pain for a few days.

## 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.

## Frequency Scans & Therapies:

The risks associated with frequency scans & therapies include increased circulation, irritation and/or itching of electrode pad sites. Patients whom are pregnant, have a pace maker or pump of any kind, those who have heart palpitations/conditions, or epilepsy/seizures are not recommended.

## Laser/Light Therapy:

The risks associated with Low Level Light Therapy can include eye damage and therefore protective eyewear must be worn during all Laser frequency/Light Sessions in office.

## Acupuncture:

Acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to regulate bodily dysfunction, to modify pain perception, and to normalize the body's physiological functions. Side effects may include, but are not limited to: minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any 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.

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: \_\_\_\_\_

# Authorization for Verbal Communication and/or to Leave Voice Mail Messages and/or Email Correspondence.

Authorization for Disclosure of Protected Health Information: This does not authorize release of copies of medical records.

## 1. Patient Information:

Name – Last, First, MI		
Street Address:		
Date of Birth:	Cell Phone#:	Home Phone#:

## 2. Information to be Disclosed: Verbal communication only re: patient's care – no copies of medical records.

<b>VERBAL Communication Between:</b> A.K. CHIROPRACTIC CENTER AND: Patient Name: _____
<b>VOICE MAIL MESSAGES:</b> <input type="checkbox"/> I authorize A.K. Chiropractic Center to send my personal health information via <b>VOICE MAIL Messages to the Phone Number(s)</b> listed above.
<b>TEXT MESSAGES:</b> <input type="checkbox"/> I authorize the <b>AK CHIROPRACTIC CENTER</b> to contact me, send appointment reminders and/or send personal health information via <b>TEXT MESSAGE</b> . I understand standard charges/rates may apply.
<b>AND/OR:</b> Leave <b>MESSAGE WITH AN INDIVIDUAL</b> who answers the phone at the number provided above. <input type="checkbox"/> Anyone <input type="checkbox"/> Names of authorized individual(s): _____

3. Most popular email services (Hotmail, Gmail, Yahoo, centurytel, etc) do not use encrypted email. In accordance with HIPAA act's guidance on email see Page 5634 on the US Dept of Health & Human Services website (<http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>). The guidelines state that if a patient has been made aware of the risks of unencrypted email and consents to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

<input type="checkbox"/> <b>Option 1 – ALLOW UNENCRYPTED EMAIL:</b> I understand the risks of unencrypted email and do hereby give permission to the A.K. Chiropractic Center to send my personal health information via unencrypted email. Email address: _____
<input type="checkbox"/> <b>Option 2 – DO NOT ALLOW UNENCRYPTED EMAIL:</b> I do not wish to receive personal health information via email.

5. This authorization will not expire unless otherwise indicated below and can be revoked in writing at anytime.

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding therapies, treatments, supplements & test results unless I limit the disclosure in writing.

Signature of Patient/Representative/guardian: \_\_\_\_\_

Date: \_\_\_\_\_ (mm/dd/yyyy)

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**SYSTEMS SURVEY FORM**

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. \_\_\_\_\_