

**SOUTHEASTERN REGIONAL MEDICAL CENTER
PHYSICIAN SERVICES**

**REGISTRATION
PATIENT**

Name _____

Mailing Address _____

Zip _____

CHART # _____

Race B ___ I ___ O ___ W ___ Sex M ___ F ___

Birth Date _____ SS# _____

Married ___ Single ___ Widow ___ Sep ___ Divorced ___

Telephone (Home) _____

(Work) _____

BILLING NAME OR HEAD OF HOUSEHOLD

Name _____

Address _____

Zip _____

Telephone _____

NEXT OF KIN (TO NOTIFY IN AN EMERGENCY)

Name _____

Address _____

Zip _____

Relationship _____

Telephone _____

INSURANCE INFORMATION

Insurance Co. _____ Policy # _____ Name of Insured _____

Date of Birth of insured _____ SS# of insured _____

Address _____ Group # _____ Relation to Patient _____

Insurance Co. _____ Policy # _____ Name of Insured _____

Address _____ Group # _____ Relation to Patient _____

Medicare # _____ Medicaid # _____

EMPLOYMENT INFORMATION

Occupation _____

Employer _____ Spouse Employer _____

Zip _____

Telephone _____ Telephone _____

AUTHORIZATION: I understand that my care is under the supervision and control of my attending physician/provider, and I consent to all medical treatments, procedures, examinations and tests which are deemed reasonably necessary in the opinion of my healthcare providers, including HIV tests, laboratory tests and x-rays. I understand that communicable diseases are reported to the Public Health Department as required by NC State law. I understand that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure and I may be asked for a more specific consent (verbal or written) to such procedures if the risk involved so indicates. I request that payment of authorized Medicare or other insurance benefits be made to SRMC Practice Clinics for any services furnished me by their health care providers. I authorize any holder of medical information about me to release to Federal, State, and/or local government agencies, and to nongovernmental sponsoring agencies, of any information medical or otherwise, which may be required in the processing of applications to them for financial coverage toward the charges for services rendered to the patient during this and related admissions.

Date _____ Signature _____

**Southeastern Regional Medical Center
PATIENT ACKNOWLEDGEMENT**

I have been given a copy of Southeastern Regional Medical Center's Notice of Privacy Practices, version 1, effective April 14, 2003.

Signature of Patient or Representative

Date

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

—

Witness

Date

FOR Southeastern Regional Medical Center USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it.

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SOUTHEASTERN REGIONAL PHYSICIAN SERVICES

affiliated with

Southeastern Regional Medical Center

PATIENT INSTRUCTIONS

I do _____/do not _____ want my name, location, general condition, and religious affiliation, released as part of Southeastern Regional Physician Services patient directory.

I do _____/do not _____ consent to the disclosure of my name, location, and religious affiliation to anyone who may inquire about me. I understand that if I do not consent to this disclosure, visitors such as family and friends, outside phone callers, florists, and members of the clergy will not be able to contact me.

I do _____/do not _____ consent for Southeastern Regional Physician Services to use and disclose my protected health information for treatment, payment or health care operations. I understand that by not consenting to disclosure of my protected health information for reasons stated above, I will be solely responsible for my hospital bill.

Signature of Patient or Representative

Date

Time AM/PM

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

—

—

—

CONSENT FORM

MEDICAL, SURGICAL, OBSTETRICS AND INFANT CARE CONSENT

I understand that my care is under the supervision and control of my attending physician, and I consent to all medical treatments, procedures, examinations and tests which are deemed reasonably necessary in the opinion of my physician and healthcare providers, including HIV tests, laboratory tests and x-rays. I understand that communicable diseases are reported to the Public Health Department as required by NC State law. I understand further that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure and I may be asked for a more specific consent (verbal or written) to such procedures if the risk involved so indicates.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Southeastern Regional Medical Center (SRMC) of hospital benefits, including major medical, otherwise payable to me, for hospital service rendered. I certify that information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is true and correct to the best of my knowledge.

I hereby authorize the use of Medicare Life Time Reserve days benefits as necessary for payment of hospital charges.

I hereby irrevocably assign to Southeastern Regional Medical Center all right, title and interest in compensation or payment received or to be received from any source as a result of injuries sustained by patient, and any person or corporation having notice of this Assignment is hereby authorized and directed to pay directly to Southeastern Regional Medical Center the amount of any indebtedness due Southeastern Regional Medical Center for services provided to the patient.

I hereby authorize insurance benefits for medical and professional services, otherwise payable to me, be assigned and paid directly to Southeastern Regional Medical Center. In the case of Medicare benefits, payment may not exceed the maximum allowance as determined by the Medicare carrier.

MEDICARE / TRICARE MESSAGE ACKNOWLEDGEMENT STATEMENT

My signature only acknowledges my receipt of this Message from Southeastern Regional Medical Center and does not waive any of my rights to request a review or make me liable for any payment.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible to Southeastern Regional Medical Center and my attending physician(s) for payment for services rendered and that assignment of insurance benefits or filing of claims by the hospital does not in any way relieve me of final responsibility for settlement of my accounts. Where this agreement is executed by a spouse or a financial guarantor, the spouse and the financial guarantor shall be jointly and severally liable with the patient, and by the execution of this form, those persons, together with the patient, do hereby promise to pay Southeastern Regional Medical Center all amounts due and owing for the subject patient's account. Should I, or my spouse or financial guarantor, enter into any agreement with Southeastern Regional Medical Center or my attending physician(s), or both, for the installment payment of any sums due and owing for services rendered on my behalf, it is understood and agreed that if any installment of principal or interest is not paid when due, all installment, at the option of Southeastern Regional Medical Center or my attending physician(s), shall become due and payable immediately. Should accounts be referred to any attorney for collection, reasonable attorney's fees and collection expenses shall be payable in addition to other amounts due.

TRANSFER OF CREDITS

I hereby authorize the transfer of monies paid to Southeastern Regional Medical Center, by or on behalf of myself and otherwise refundable to me to Southeastern Regional Medical Center accounts for which I am responsible.

VALUABLES

The Southeastern Regional Medical Center will not be responsible for money, jewelry or other property or valuables of patients. UNLESS they are placed in a hospital Valuables envelope and deposited with a Nursing Supervisor and a receipt obtained therefore. UNDER NO OTHER CIRCUMSTANCES WILL THE HOSPITAL BE LIABLE FOR PROPERTY OF PATIENT.

NOTICE OF PRIVACY PRACTICES AKNOWLEDGMENT STATEMENT

I acknowledge that I have received a copy of Southeastern Regional Medical Center's Notice of Privacy Practices, Version 1 effective April 14, 2003.

RECEIPT OF INFORMATION ACKNOWLEDGEMENT STATEMENT

I acknowledge that I have received a copy of Joint Commission's SPEAK UP brochure, Southeastern Regional Medical Center's patient rights and responsibilities, SRMC's Code Help brochure, a Hand Hygiene brochure, and that I have been informed that my services with SRMC may result in bills from additional providers not employed by SRMC including but not limited to Radiologists, Anesthesiologist, Surgeons, Pathologist, Cardiologists, any my primary care physician.

DATE _____ PATIENT/REPRESENTATIVE (GUARDIAN OR RESPONSIBLE PARTY) _____ RELATIONSHIP _____
WITNESS _____ WITNESS _____

***If the Signature is not that of Patient, Parent, or Guardian, indicate below the reason the Patient is unable to sign.

Reason Patient Unable to Sign _____



2-CONFRM

Name: _____ Birthdate: _____ Constitution : _____

Circle the answer that best reflects the intensity of each symptom at this time.

0 = Never 1 = Seldom 2 = Occasional 3 = Often

Unit I: DIGESTION

Part A: LOW ACIDITY

- 1. Indigestion 0 1 2 3
- 2. Abdominal Bloating 0 1 2 3
- 3. Feel too full after eating 0 1 2 3
- 4. Constipation 0 1 2 3
- 5. Belching/Burping 0 1 2 3
- 6. Diminished appetite 0 1 2 3
- 7. Stomach growls/ gurgles 0 1 2 3
- 8. Any known food allergies? 0 1 2 3

Part B: HIGH ACIDITY

- 1. Stomach pains just before or after meals 0 1 2 3
- 2. Stomach pains with no apparent reason 0 1 2 3
- 3. Stomach pain relieved by carbonated drinks 0 1 2 3
- 4. Stomach pain relieved by milk / cream 0 1 2 3
- 5. Emotional upset causes stomach pain 0 1 2 3
- 6. Heartburn immediately after meals 0 1 2 3
- 7. Constant need for antacids 0 1 2 3
- 8. "Butterfly feeling" in stomach 0 1 2 3
- 9. Family history of ulcer / gastritis? No Yes
- 10. Ulcer in the past year? No Yes
- 11. Current ulcer? No Yes
- 12. Very dark or black stool? No Yes
- 13. Hot / spicy food cause stomach irritation? No Yes

Unit II: ASSIMILATION

Part A: SMALL INTESTINE

- 1. Stomach cramps 0 1 2 3
- 2. Indigestion immediately after eating 0 1 2 3
- 3. Feel tired after meals 0 1 2 3
- 4. Flatulence (gas) 0 1 2 3
- 5. Constipation / diarrhea (alternating) 0 1 2 3
- 6. Fiber rich diet won't stop constipation 0 1 2 3
- 7. Loose stool 0 1 2 3
- 8. Presence of mucus in stool 0 1 2 3
- 9. Stool poorly formed 0 1 2 3
- 10. Four or more large stools daily 0 1 2 3
- 11. Stools have foul odor 0 1 2 3
- 12. Pain in left side of abdomen 0 1 2 3
- 13. History of pimples, skin eruption? No Yes
- 14. Any known food allergies? No Yes

Part B: LARGE INTESTINE

- 1. Diarrhea 0 1 2 3
- 2. Recurrent infections / colds 0 1 2 3
- 3. History of kidney and/or bladder infection 0 1 2 3
- 4. Yeast infection (including vaginal) 0 1 2 3
- 5. Frequent abdominal cramps 0 1 2 3
- 6. Fingernail and/or toenail fungus 0 1 2 3
- 7. Diarrhea and constipation (alternating) 0 1 2 3
- 8. Chronic constipation 0 1 2 3
- 9. Use of antibiotics in past year? No Yes
- 10. Meat eater? No Yes
- 11. Vision deteriorating rapidly? No Yes

Unit III: PANCREAS

Part A: LOW BLOOD SUGAR

- 1. Dizziness / dimmed vision when standing up suddenly 0 1 2 3
- 2. Strong desire / craving for sweets 0 1 2 3
- 3. Sweets / alcohol promptly relieve headaches 0 1 2 3
- 4. Irritable if a meal is missed or delayed 0 1 2 3
- 5. Hungry most of the time 0 1 2 3
- 6. Constantly anxious, nervous, worrisome 0 1 2 3
- 7. Frequently drowsy, impatient, moody 0 1 2 3
- 8. Need for caffeine to get going 0 1 2 3
- 9. Rapid heartbeat after eating sweets 0 1 2 3
- 10. Hungry 1-3 hours after eating 0 1 2 3
- 11. Restless, poor concentration 0 1 2 3
- 12. Forgetful; poor memory 0 1 2 3
- 13. Feel shaky, weak, or fatigued 0 1 2 3
- 14. Feel better / calmer after eating? No Yes
- 15. Low protein / high carbohydrate diet? No Yes

Part B: HIGH BLOOD SUGAR

- 1. Decreased resistance to infection 0 1 2 3
- 2. Slow healing cuts, wounds, etc. 0 1 2 3
- 3. Night sweats 0 1 2 3
- 4. Heightened thirst 0 1 2 3
- 5. Increased appetite 0 1 2 3
- 6. Eating sweets does not alleviate cravings 0 1 2 3
- 7. Fatigue, mental confusion 0 1 2 3
- 8. Poor, deteriorating eyesight 0 1 2 3
- 9. Itchy skin, boils and/or leg sores 0 1 2 3
- 10. History of diabetes in family? No Yes
- 11. Sugar (glucose) detected in urine? No Yes
- 12. Low protein / high carbohydrate diet? No Yes
- 13. Overweight? No Yes

Unit IV: LIVER / GALLBLADDER

Part A-1: LIVER / GALLBLADDER

- 1. Abdominal pain after eating fatty foods 0 1 2 3
- 2. Pain in the side under right rib cage 0 1 2 3
- 3. Pain or tender big toe 0 1 2 3
- 4. Hard / dry stool (painful to pass) 0 1 2 3
- 5. Stool color is grayish (light in color) 0 1 2 3
- 6. Stool has foul odor 0 1 2 3
- 7. Less than one daily bowel movement 0 1 2 3
- 8. History of constipation 0 1 2 3
- 9. Gray colored skin 0 1 2 3
- 10. Headaches following meals 0 1 2 3
- 11. Recurring sour, bitter taste in mouth 0 1 2 3
- 12. Red blood in stool? No Yes

Part A-2: LIVER / GALLBLADDER

- 1. Yellow sclera (white of the eyes) 0 1 2 3
- 2. Bad breath or body odor 0 1 2 3
- 3. Tired / sleepy after meals 0 1 2 3
- 4. Dandruff 0 1 2 3
- 5. Retain water 0 1 2 3
- 6. Dry skin and/or hair 0 1 2 3
- 7. Eat at fast food restaurants 0 1 2 3
- 8. Impatient, impulsive, easy to anger 0 1 2 3

Part A-2: LIVER / GALLBLADDER (cont)

- 9. Vision problems / red or dry eyes? No Yes
- 10. Have had jaundice or hepatitis? No Yes
- 11. High blood cholesterol and/or low HDL? No Yes

Unit V: URINARY SYSTEM

Part A: KIDNEY / BLADDER

- 1. Constant feeling of a full bladder 0 1 2 3
- 2. Loss of control holding urine 0 1 2 3
- 3. Drip / dribble after urination 0 1 2 3
- 4. Blood or pus in urine (in any amount) 0 1 2 3
- 5. Hazy or cloudy urine 0 1 2 3
- 6. Urine has odor / strong smell 0 1 2 3
- 7. Long intervals between urination 0 1 2 3
- 8. Straining to urinate with scant passage 0 1 2 3
- 9. Awaken in middle of night to urinate 0 1 2 3
- 10. Feeling of fear / insecurity 0 1 2 3
- 11. Dark circles under eyes 0 1 2 3
- 12. Pain or pressure in middle of back 0 1 2 3
- 13. Intermittent pain in urethra 0 1 2 3
- 14. History of bladder infection / cystitis? No Yes
- 15. Recent use of antibiotics – kidney/bladder infections? No Yes
- 16. Recent bladder surgery (including A/P repair) No Yes

Unit VI: THYROID

Part A-1: THYROID

- 1. Sensitivity to cold / wet weather 0 1 2 3
- 2. Hands and feet are cold 0 1 2 3
- 3. Constantly tired / fatigued 0 1 2 3
- 4. Lack of stamina for daily chores 0 1 2 3
- 5. Diagnosis of attention deficit disorder (ADD) 0 1 2 3
- 6. Eyes appear bulging or swollen 0 1 2 3
- 7. Skin is dry (lacks moisture) 0 1 2 3
- 8. Difficulty waking up in the morning 0 1 2 3
- 9. Depressed, apathetic, lethargic 0 1 2 3
- 10. Lack of or diminished sex drive 0 1 2 3
- 11. Irritability / mood swings when eating sweets 0 1 2 3

Part A-2: THYROID

- 12. Constipation? 0 1 2 3
- 13. Gain weight easily? No Yes
- 14. Basal / armpit temperature less than normal? No Yes
- 15. Slow reflexes / reaction time? No Yes
- 16. Infertility / impotency? No Yes
- For women only:*
- 17. Heavy / profuse menstrual bleeding 0 1 2 3
- 18. Premenstrual tension / stress 0 1 2 3

Unit VII: ADRENAL

Part A: ADRENAL

- 1. Unable to tolerate much exercise 0 1 2 3
- 2. Catch colds or get sick easily 0 1 2 3
- 3. Sensitive to air pollutants, chemicals, smoke 0 1 2 3
- 4. Breathing is labored / difficult 0 1 2 3
- 5. Feelings of weakness / shakiness 0 1 2 3
- 6. Moments of depression 0 1 2 3
- 7. Rapid mood swings 0 1 2 3
- 8. Energy lag in morning to mid-afternoon 0 1 2 3
- 9. Need for caffeine to get going 0 1 2 3
- 10. Intermittent constipation 0 1 2 3
- 11. Dark circles beneath the eyes 0 1 2 3
- 12. Dizzy / light headed upon standing 0 1 2 3
- 13. Lack of mental alertness (mental fog) 0 1 2 3

Part A: ADRENAL (cont)

- 14. Retain Water 0 1 2 3
- 15. Insomnia 0 1 2 3
- 16. Eyes sensitive to bright / direct light 0 1 2 3
- 17. Use cortisone, prednisone, steroids No Yes

Unit VIII: FEMALE

Part A: SYMPTONS DURING MENSTRUATION

- 1. Monthly weight gain 0 1 2 3
- 2. Feeling of depression / anxiety 0 1 2 3
- 3. Moodiness / irritability / anger 0 1 2 3
- 4. Bloating / swelling 0 1 2 3
- 5. Nausea / vomiting 0 1 2 3
- 6. Tenderness in breast area 0 1 2 3
- 7. Leg cramps / tenderness 0 1 2 3
- 8. Lower back ache 0 1 2 3
- 9. Headaches 0 1 2 3
- 10. Easily distracted 0 1 2 3
- 11. Asthma / bronchitis attacks? No Yes
- 12. Suicidal feelings? No Yes

Part B: AMENORRHEA (ABSENCE OF MENSTRUATION)

- 1. Vaginal itching / discharge 0 1 2 3
- 2. Missed periods 0 1 2 3
- 3. Crave sweets or additional food 0 1 2 3
- 4. More than 1 cycle per month 0 1 2 3
- 5. Low or no desire for sex? No Yes
- 6. Pain during intercourse? No Yes
- 7. Menstruation started after age 15? No Yes
- 8. Unable to get pregnant? No Yes
- 9. Number of miscarriages (if any) 0 1 2 3+
- 10. Number of abortions (if any) 0 1 2 3+

Part C: DYSMENORRHEA (PAINFUL MENSTRUATION)

- 1. Anxiety about arrival of menstrual cycle 0 1 2 3
- 2. Low abdominal pain 0 1 2 3
- 3. Dull pain radiation to lower back or legs 0 1 2 3
- 4. Menstrual pain 0 1 2 3
- 5. Menstrual pain becomes progressively worse 0 1 2 3
- 6. Pain and cramps without blood flow 0 1 2 3
- 7. Light, sparse blood flow 0 1 2 3
- 8. Heavy menstrual bleeding 0 1 2 3
- 9. Nausea / vomiting prior to or during periods 0 1 2 3
- 10. Need to lie down first 1 or 2 days of period 0 1 2 3
- 11. Increased urinary frequency 0 1 2 3
- 12. Pelvic soreness 0 1 2 3
- 13. Diarrhea associated with menstruation 0 1 2 3
- 14. Headache during periods 0 1 2 3
- 15. Abdominal bloating 0 1 2 3
- 16. Craving for sweets (especially chocolate) 0 1 2 3

Part D: FIBROUS TISSUE AND CYSTS

- 1. Irregularities / soreness / lumps in vaginal area 0 1 2 3
- 2. Pain in ovaries 0 1 2 3
- 3. Retain water 0 1 2 3
- 4. Swollen feeling 0 1 2 3
- 5. Premenstrual breast pain or discomfort 0 1 2 3
- 6. Breast lumps? No Yes
- 7. Recent abnormal pap smear? No Yes
- 8. Family history of breast cancer? No Yes
- 9. Ovarian / uterine cyst? No Yes
- 10. Recent use of hormones? No Yes
- 11. Recent use of birth control device / medication? No Yes

Part E: CHANGE OF LIFE (AGE 35 AND OVER)

| | | | | |
|--|----|-----|---|---|
| 1. Sweating throughout the day | 0 | 1 | 2 | 3 |
| 2. Night sweats | 0 | 1 | 2 | 3 |
| 3. Hot flashes | 0 | 1 | 2 | 3 |
| 4. Mood swings | 0 | 1 | 2 | 3 |
| 5. Insomnia / light sleeper | 0 | 1 | 2 | 3 |
| 6. Craving for sweets (especially chocolate) | 0 | 1 | 2 | 3 |
| 7. Heavy bleeding two weeks at a time | 0 | 1 | 2 | 3 |
| 8. Dryness of pubic hair and vaginal area | 0 | 1 | 2 | 3 |
| 9. Vaginal pain / itching | 0 | 1 | 2 | 3 |
| 10. Painful intercourse | 0 | 1 | 2 | 3 |
| 11. Hysterectomy? | No | Yes | | |
| 12. Osteoporosis? | No | Yes | | |

Unit IX: MALE**Part A: PROSTATE**

| | | | | |
|--|---|---|---|---|
| 1. Weakened urinary flow | 0 | 1 | 2 | 3 |
| 2. Burning / painful urination | 0 | 1 | 2 | 3 |
| 3. Bladder feels full | 0 | 1 | 2 | 3 |
| 4. Blood / pus in urine (any amount) | 0 | 1 | 2 | 3 |
| 5. Awakening to urinate during the night | 0 | 1 | 2 | 3 |
| 6. Drip / dribble after urination | 0 | 1 | 2 | 3 |
| 7. Fatigue in legs or lower back | 0 | 1 | 2 | 3 |
| 8. Decreased libido / sex drive | 0 | 1 | 2 | 3 |
| 9. Pain or discomfort upon ejaculation | 0 | 1 | 2 | 3 |

Part B: MALE REPRODUCTION

| | | | | |
|--|----|-----|---|---|
| 1. Coldness / pain in genital area | 0 | 1 | 2 | 3 |
| 2. Difficulty in maintaining an erection | 0 | 1 | 2 | 3 |
| 3. Fear / anxiety about sexual intimacy | 0 | 1 | 2 | 3 |
| 4. Premature ejaculation | 0 | 1 | 2 | 3 |
| 5. Weak kneel / lower back | 0 | 1 | 2 | 3 |
| 6. Infertility? | No | Yes | | |
| 7. Varicose veins on scrotum? | No | Yes | | |
| 8. Sperm count low? | No | Yes | | |
| 9. Lack of / diminished sex drive? | No | Yes | | |

Part C: GENITAL INFECTION

| | | | | |
|-----------------------------------|----|-----|---|---|
| 1. Genitals swollen and/or tender | 0 | 1 | 2 | 3 |
| 2. Groin area swollen / inflamed | 0 | 1 | 2 | 3 |
| 3. Multiple sexual partners | 0 | 1 | 2 | 3 |
| 4. Discharge from penis? | No | Yes | | |
| 5. Rash on penis / pubic area? | No | Yes | | |
| 6. Current venereal disease? | No | Yes | | |
| 7. Venereal disease in the past? | No | Yes | | |

Unit X: CIRCULATORY SYSTEM**Part A: HEART**

| | | | | |
|--|------|-------|------|---|
| 1. Nervous / jittery for no apparent reason | 0 | 1 | 2 | 3 |
| 2. Calf muscles cramp when walking | 0 | 1 | 2 | 3 |
| 3. Arrhythmia / chest pain when walking | 0 | 1 | 2 | 3 |
| 4. Shortness of breath during minor activity | 0 | 1 | 2 | 3 |
| 5. Rapid heartbeat during minor activity | 0 | 1 | 2 | 3 |
| 6. Palpitations / erratic heartbeat | 0 | 1 | 2 | 3 |
| 7. Numbness / pain in left arm | 0 | 1 | 2 | 3 |
| 8. Heaviness in legs | 0 | 1 | 2 | 3 |
| 9. Edema / swelling of feet and ankles | 0 | 1 | 2 | 3 |
| 10. Regular exercise? | 0 | 1 | 2 | 3 |
| 11. Frequent aerobic exercise? | No | Yes | | |
| 12. Red, swollen nose? | No | Yes | | |
| 13. Usual resting heart rate | Slow | Norm. | Fast | |

Part B: CIRCULATION

| | | | | |
|--|-----|------|------|---|
| 1. Get angry / excited easily | 0 | 1 | 2 | 3 |
| 2. Headaches / migraines for no apparent reason | 0 | 1 | 2 | 3 |
| 3. Poor concentration / foggy brain | 0 | 1 | 2 | 3 |
| 4. Ringing in ears | 0 | 1 | 2 | 3 |
| 5. Cold extremities (hands / feet) | 0 | 1 | 2 | 3 |
| 6. Numbness in extremities (hands / feet) | 0 | 1 | 2 | 3 |
| 7. Blushing for no apparent reason | 0 | 1 | 2 | 3 |
| 8. Speech slurred / sloppy | 0 | 1 | 2 | 3 |
| 9. Calf muscles cramp when walking | 0 | 1 | 2 | 3 |
| 10. Poor circulation | 0 | 1 | 2 | 3 |
| 11. Systolic and diastolic pressures widely separated? | No | Yes | | |
| 12. Lower ear lobe has vertical crease? | No | Yes | | |
| 13. Heart attack? | No | Yes | | |
| 14. History of stroke? | No | Yes | | |
| 15. Resting blood pressure | Low | Norm | High | |

Part C: HIGH BLOOD PRESSURE

| | | | | |
|--|----|-----|---|---|
| 1. Pain in back of head upon arising in the AM | 0 | 1 | 2 | 3 |
| 2. Dizziness / lightheadedness / vertigo | 0 | 1 | 2 | 3 |
| 3. Rapid pulse / shortness of breath | 0 | 1 | 2 | 3 |
| 4. Easily tired by minor exertion | 0 | 1 | 2 | 3 |
| 5. Visual disturbance | 0 | 1 | 2 | 3 |
| 6. Exercise regularly? | No | Yes | | |
| 7. Blood pressure higher than it should be? | No | Yes | | |
| 8. Systolic and diastolic pressures close to each other? | No | Yes | | |

Part D: LYMPHATIC

| | | | | |
|--|----|-----|---|---|
| 1. Need to clear throat, particularly in AM | 0 | 1 | 2 | 3 |
| 2. Swelling in throat / neck | 0 | 1 | 2 | 3 |
| 3. Skin irritation / rash | 0 | 1 | 2 | 3 |
| 4. Pressure / congestion in or behind ears | 0 | 1 | 2 | 3 |
| 5. Do you exercise regularly? | No | Yes | | |
| <i>For women only:</i> | | | | |
| 6. Nodules or tenderness in breasts | 0 | 1 | 2 | 3 |
| 7. Swelling in feet / ankles upon waking in AM | 0 | 1 | 2 | 3 |
| 8. Puffiness beneath eyes in the morning | 0 | 1 | 2 | 3 |

Unit XI: RESPIRATORY SYSTEM**Part A: RESPIRATORY SYSTEM**

| | | | | |
|---|----|-----|---|---|
| 1. Shortness of breath / labored breathing | 0 | 1 | 2 | 3 |
| 2. Chest tightness / pain | 0 | 1 | 2 | 3 |
| 3. Recurring / chronic cough | 0 | 1 | 2 | 3 |
| 4. Coughing up phlegm or blood | 0 | 1 | 2 | 3 |
| 5. Chest colds | 0 | 1 | 2 | 3 |
| 6. Sensitive to smog / perfumes, etc | 0 | 1 | 2 | 3 |
| 7. Live / work with people who smoke | 0 | 1 | 2 | 3 |
| 8. Smoker – currently or in past 3 years? | No | Yes | | |
| 9. Chronic lung infections? | No | Yes | | |
| 10. Exposure to chemicals, pesticides or radiation? | No | Yes | | |

Unit XII: IMMUNE SYSTEM**Part A: LOW-FUNCTION (HYPO IMMUNITY)**

| | | | | |
|---|---|---|---|---|
| 1. Bleeding or sensitive gums | 0 | 1 | 2 | 3 |
| 2. Runny / sniffy nose | 0 | 1 | 2 | 3 |
| 3. Nose bleeds for no apparent cause | 0 | 1 | 2 | 3 |
| 4. Loss of sense of smell or taste | 0 | 1 | 2 | 3 |
| 5. Chest and throat infections | 0 | 1 | 2 | 3 |
| 6. Fever blisters, cold sores | 0 | 1 | 2 | 3 |
| 7. Wounds heal slowly | 0 | 1 | 2 | 3 |
| 8. Hair thinning / falling out / slow growing | 0 | 1 | 2 | 3 |
| 9. Ear infection / congestion | 0 | 1 | 2 | 3 |
| 10. Slow recovery from cold or flu | 0 | 1 | 2 | 3 |

Part A: LOW-FUNCTION (HYPO IMMUNITY)(cont)

- 11. Catch colds / flu easily, despite precautions 0 1 2 3
- 12. Skin on back of arms is rough / bumpy 0 1 2 3
- 13. Lymph glands swell? No Yes

Part B-1: EXCESSIVE FUNCTION (HYPER IMMUNITY)

- 1. Known food sensitivity / allergy 0 1 2 3
- 2. Some foods cause illness / anxiety / depression 0 1 2 3
- 3. Stomach pain / G.I. tract discomfort 0 1 2 3
- 4. Swallowing tablets is difficult 0 1 2 3
- 5. Skin disorder / rashes? No Yes
- 6. Bronchitis / asthma / chronic lung problems? No Yes
- 7. Recurring migraine headaches? No Yes
- 8. Mucus in throat / chest 0 1 2 3
- 9. Low grade fever from time to time 0 1 2 3
- 10. Swollen / inflamed joints, body aches 0 1 2 3
- 11. Swollen or sore tongue 0 1 2 3
- 12. Eye itch / puffiness / discharge? No Yes
- 13. Ear stuffy / congested 0 1 2 3
- 14. Sinus infection 0 1 2 3

Part B-2: EXCESSIVE FUNCTION (HYPER IMMUNITY)

- 15. Runny nose / post nasal drip 0 1 2 3
- 16. Alternating diarrhea and constipation 0 1 2 3
- 17. Bed wetting? No Yes
- 18. Attention deficit / hyperactivity? No Yes
- 19. Use aspirin, Tylenol, ibuprofen? No Yes
- 20. Use cortisone, prednisone, steroids? No Yes
- 21. Mouth breather? No Yes

Unit XIII: BONE

Part A: BONE INTEGRITY

- 1. Cavities / dental weaknesses 0 1 2 3
- 2. Bones sore / painful 0 1 2 3
- 3. Pain in joints / extremities 0 1 2 3
- 4. Eat meat at most meals? No Yes
- 5. 3+ cups/day of carbonated beverages? No Yes
- 6. Gingivitis / gum sensitivity? No Yes
- 7. Use antacids at least once a day? No Yes
- 8. Presently wear dentures? No Yes
- 9. Any known bone deformities? No Yes
- 10. Diagnosed with arthritis / rheumatism? No Yes
- 11. Diagnosed with osteoporosis? No Yes
- 12. Recent bone fracture (past 2 years)? No Yes
- For women only:*
- 13. Post menopausal? No Yes

Unit XIV: SOFT TISSUE

Part A: MUSCLE

- 1. Muscle cramps 0 1 2 3
- 2. Muscle spasms 0 1 2 3
- 3. Tension in shoulder muscles 0 1 2 3
- 4. Pain in neck (fibromyalgia) 0 1 2 3
- 5. Unable to sit for long periods 0 1 2 3
- 6. Still upon awakening 0 1 2 3
- 7. Pain / cramps in arms, legs, hands and feet 0 1 2 3
- 8. Fibromyalgia? No Yes

Part B: CONNECTIVE TISSUE

- 1. Injured tendons / ligaments 0 1 2 3
- 2. Double jointed 0 1 2 3
- 3. Aching joints 0 1 2 3
- 4. Back pain 0 1 2 3
- 5. Tendonitis 0 1 2 3
- 6. Knees / elbows swollen 0 1 2 3

Part B: CONNECTIVE TISSUE (cont)

- 7. Bursitis 0 1 2 3
- 8. Slipped / herniated disc? No Yes
- 9. Height loss? No Yes
- 10. Bruise / injure easily? No Yes

Unit XV: NERVOUS SYSTEM

Part A: NERVOUS SYSTEM

- 1. Tingling sensation under the skin 0 1 2 3
- 2. Noises / ringing in ears 0 1 2 3
- 3. Loss of balance / vertigo 0 1 2 3
- 4. Abnormally exhausted 0 1 2 3
- 5. Light headedness / dizziness 0 1 2 3
- 6. Nervousness / restlessness 0 1 2 3
- 7. Grip strength weaker than usual 0 1 2 3
- 8. Arms and legs feel heavy 0 1 2 3
- 9. Numbness in hands and feet 0 1 2 3
- 10. Heavy headed feeling 0 1 2 3
- 11. Tremor in hands 0 1 2 3
- 12. Clumsiness / bad coordination 0 1 2 3
- 13. Convulsions / seizures? No Yes
- 14. Have shingles / herpes? No Yes
- 15. Accident prone? No Yes
- 16. Need for 10 or more hours of sleep? No Yes
- 17. Noticeable loss of muscle mass? No Yes

Unit XVI: SLEEP

Part A: SLEEP PATTERNS

- 1. Nightmares / intense dreams 0 1 2 3
- 2. Insomnia 0 1 2 3
- 3. "Toss and turn" sleeper 0 1 2 3
- 4. Restless legs when laying down 0 1 2 3
- 5. Currently using a sleep aid? No Yes
- 6. Wake up frequently during the night? No Yes
- 7. Wake early, can't fall back to sleep? No Yes
- 8. Sleep walk / talks in sleep? No Yes