For us to accurately create an individualized plan for you to live an E.P.I.C. life, it is imperative that we get to know you on many different levels to help you overcome what is either holding you back or keeping you from being healthy. The most important question we will try to answer is the "why". "Why" are you in the state of health you are in? Is it due to lack of movement; improper nutrition; or is it an emotional/relational roadblock that is culprit. At E.P.I.C. Chiropractic, we look at the body as a whole, instead of individual systems or parts; this requires us to ask questions most physicians do not. As in all physician's offices, your health history and privacy will be held to the highest of standards.

Our goal for every individual that starts care with us is to make sure their body is functioning like an **E**lite **P**erformance machine that it is, through our **I**ndividualized **C**are approach, to ensure everyone lives an E.P.I.C. life. We believe that when you commit to making you a priority, you begin to live this life with a purpose. (You are a better you, when you take care of you!)

Your E.P.I.C. life awaits!

Personal Demographics

Name: _____ M.I.: ___ Last Name: _____ Date: ___/___/___

Preferred Name: _____

Mailing Address: _____

Apt#: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Preferred Contact: ___Home ___Work ___Cell ___Email ___Any

Sex: F____ M____ DOB: _____ / _____ /_____ Age: _____ S.S.#: _____ - ___ - _____

Height: _____ Ft. _____ Inches Weight: _____ Pounds

Occupation: _____ Employer: _____ Years: _____

Marital Status: ___Minor ___Single ___Married ___Divorced ___Separated ___Widowed

Spouse's Name: _____ Occupation: _____

Number of Children: _____ Names & Ages: _____

Who referred you or how did you hear about us? _____

What do you know about what we do here? _____

E.P.I.C. Chiropractic

Initials: _____

In the event of an Emergency

Who should we contact: _____ Relation: _____

Home Phone: (____) _____ Work or Cell Phone: (____) _____

Primary Care Physician: _____ Phone: _____

May we update them on your condition? ____Yes ____No

Insurance Information

* If insured please provide your insurance card to copy *

Carrier: _____ Phone: _____

ID #: _____ Group #: _____

Relationship to insured: ____Self ____*Spouse ____*Parent ____*Guardian

* If other than "Self" provide Name and Date of Birth of insured

Insured's Name: _____ DOB: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I authorize the office to release any medical information and to complete any usual and customary reports to assist in collecting information from my insurance company. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials: _____

Reason for Seeking Care

What is your reason for seeking care at E.P.I.C. Chiropractic? _____

_____

When did this begin? (If applicable) _____

How did it begin: ____Sudden ____Gradually ____Unknown

Etiology: ____Fall ____Repetitive ____Auto ____Sports ____Work ____Chronic

Explain: _____

_____

Interferes with: ___Work ___School ___Sleep ___Daily Routine ___Hobbies/Interests

Is it getting worse: ___Yes ___No ___Constant ___Comes and Goes

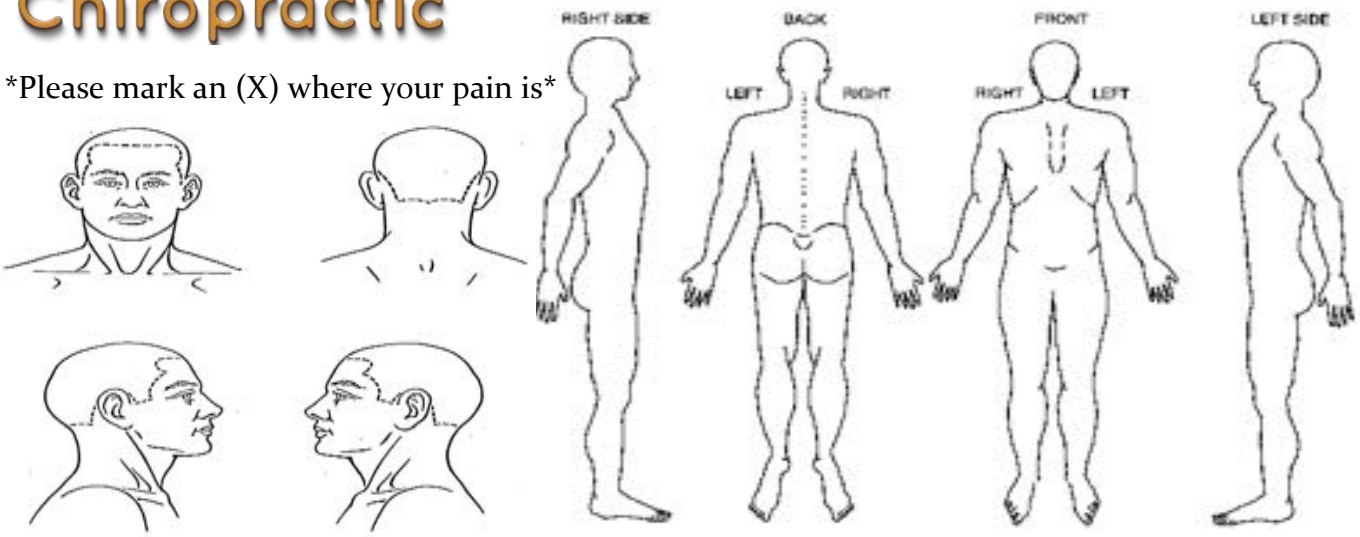
Have you had a similar episode in the past (if so, when?): _____

What did you do to recover from prior episode? _____

E.P.I.C. Chiropractic

Initials: _____

Please mark an (X) where your pain is



Conditions or Illnesses

Current	Past	Condition / Illness	Current	Past	Condition / Illness
		AIDS/HIV			Anemia
		Arthritis			Emphysema
		Asthma			Heart Trouble
		Breast Lumps			Herniated Disc
		Cancer			High Blood Pressure
		Diabetes			Liver Trouble
		Dislocated Joints			Low Blood Pressure
		Epilepsy			Migraines
		Headaches			Pacemaker
		Kidney Trouble			Rheumatoid Arthritis
		Prostate Trouble			Stroke
		Scoliosis			Tuberculosis
		Sinus Trouble/Allergies			Tumors/Growths
		Thyroid Issues			Ulcer

Family History

Condition	✓	**yes**	**Family Member**	**Condition**	✓	**yes**	**Family Member**
Anemia				Heart Trouble			
Arthritis				High Blood Pressure			
Cancer				Joint Problems			
Congenital Disease				Kidney Disease			
Diabetes				Mental Illness			
Disc Problems				Osteoporosis			
Genetic Disease				Scoliosis			
Headaches				Stroke			
Other							

E.P.I.C. Chiropractic

Initials: _____

State of Health

Please **Check** all the professionals you've seen (past & present)

___Medical Doctor ___Chiropractor ___Osteopath ___Physical Therapist ___Psychologist

___Counselor ___Other: _____

Previously diagnosed conditions and age: _____

_____

Please list all the medications/prescriptions you are currently taking: _____

_____

What Supplements are you currently taking? _____

_____

List all surgeries and their dates: _____

_____

List all car accidents you have been in (even the "small", "minor", or "fender bender"): _____

_____

Have you ever broken a bone? Which one(s): _____

Have you ever passed out (fainted) or been knocked unconscious? If so, how and when: _____

_____

List any other injuries or traumas you have experienced: _____

_____

What are some of the things your health condition is keeping you from doing? _____

_____

What is your level of commitment to yourself and your health? **1 2 3 4 5 6 7 8 9 10**

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life? _____

_____

E.P.I.C. Chiropractic

Initials: _____

Getting to know you better

Below is a list of question that will help us get to know your life story better so that we can more accurately tailor a treatment plan to fit you and no one else but you. Please answer to the best of your ability and remember all this information will be kept to the utmost highest privacy standards.

I like who I am: ___Yes or ___No I love my career / job: ___Yes or ___No

I am an ___Introvert ___Extrovert or ___Ambivert

Do you smoke? ___Yes or ___No if Yes, do you want to quit? ___Yes or ___No

What is the most stressful part of your life? ___Home ___Work ___Health ___Friends

When was the last time you took a vacation? _____ Where did you go? _____

Would you like for us to pray with or for you? ___Yes ___No or ___Unsure

Do you want to make a lifestyle change? ___Yes or ___No

What do you want out of life? _____

Do you have any hobbies? ___Yes or ___No If Yes, what are they? _____

_____

Do you have any pets? ___Yes or ___No If yes, what kind? _____

Are you interested in changing your diet? ___Yes or ___No

How many bowel movements do you have a day? ____**1** ____**2** ____**3+**

____Every other day or Every ___ days

Do you ever "pop" or "crack" your neck or back? ___Yes or ___No

Do (or did) you get along with your parents? ___Yes or ___No

What is the best part of your life? _____

What do you fear most about your life? _____

What would you like your life to look like 1 year from now? _____

_____

If you were granted one wish, what would YOU WANT it to be and why? _____

_____

What do you want to achieve (your #1 priority) in the next 90 days? _____

_____

Initials: _____

Financial Policy

It is important for you to fully understand that our financial, credit, and collection policies are a necessary part of assuring the financial resources needed to maintain this healthcare facility for our patients and community. Please read this policy statement carefully and feel free to ask any questions in any area. We ask that you sign this statement when you have read and understand each point.

- Payment for services is due at the time services are rendered, unless other arrangements have been made with Dr. Richard J Simpson DC, MS. I understand that Dr. Simpson is the only person who can change payment policy at E.P.I.C. Chiropractic, PLLC.
- E.P.I.C. Chiropractic, PLLC is a participating provider for several insurance carriers and health plans. The type of insurance you have will determine the level of payment responsibility you will have on the date of service. If you have health insurance, this is an agreement between you and your insurance carrier to pay for medical care, and not a substitute for payment at the time of service. You are responsible for your entire bill regardless of your insurance company's failure to pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company, and we will not enter into any dispute with them. For those insurance companies that we have contracted with as a participating provider we will provide services within their contracted fee schedule and guidelines. As a service to you our office will file insurance claims on your behalf to your insurance company.
- I authorize E.P.I.C. Chiropractic to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed to this office. Co-payments, annual deductibles, and coinsurance amounts are the responsibility of the patient and are due at the time of service. If unusual circumstances should make it difficult for you to meet our credit terms, we invite you to discuss with our office staff any payment options available to you.
- Any services not covered by the insurance company will be the patient's responsibility.
- Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
- If you discontinue care for any reason, other than discharge by the doctor, your bill is due and payable in full immediately. Regardless of any previous arrangements or discounts.
- In the event that my account is turned over to collections for nonpayment at the 90(ninety) day mark, I understand and accept that my past due amount will be assessed an additional fee of 40% (forty percent) and that I will be responsible for paying this fee in addition to the outstanding balance on my account.
- Workers compensation patients are required to bring or have completed Form 113 by your employer as Kentucky Law Requires this.
- Auto and personal injury patients are required to bring insurance information to include the claimant name, insured name, claim number, and date of loss. If an attorney represents your interest, we ask that you supply his/her name, address and telephone number and sign an attorney lien form.
- We charge for special forms and letters to be sent to lawyers, insurance companies, disability boards, auto claims and other physicians. The amount charged may/will vary with the amount of paper and time involved.

A returned check fee of $30.00 will be charged on all checks that are returned as non-sufficient funds (NSF) or non-processable.

Date: _____ Print Patient Name: _____

Signature: _____

Initials: _____

HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature: _____

Consent to Treatment with Benefits, Risks and Alternatives

This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. The nature of chiropractic treatment: the doctor will use his/her hands, mechanical device, or instrument in order to move the joints and/or soft tissues of the body. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", you may feel the movement of the joint. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or for the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

- **Possible Risks**: as with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.
- **Alternatives to Treatment**: over-the-counter analgesics, medical care, in some cases hospitalization and/or surgery, along with other non-traditional modes such as acupuncture, massage, reiki…etc.
- **Risks of Remaining Untreated**: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.
- **Benefits**: Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. It can increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By Signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Date: _____ Print Patient Name: _____

Patient or Guardian Signature: _____

Doctor's Signature: _____

E.P.I.C. Chiropractic

Doctor's Initials: _____

FOR USE BY CLINIC STAFF

TVAS, Diagnosis, FOA, & Tx Plan

Pain Right Now: **1 2 3 4 5 6 7 8 9 10**

Pain on Average: **1 2 3 4 5 6 7 8 9 10**

Pain at its Worst: **1 2 3 4 5 6 7 8 9 10**

Diagnosis:

1.) _____ 2.) _____

3.) _____ 4.) _____

FOA: _____

Tx Plan:

SYSTEMS SURVEY FORM
(Restricted to Professional Use)

PATIENT_____ AGE_____ DOCTOR_____ DATE_____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank.**
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs 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 seem 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 1/2 - 1 hour after
104 – 1 2 3 Mucous colitis or "irritable bowel"
105 – 1 2 3 Gas shortly after eating
106 – 1 2 3 Stomach "bloating" eating; may be up to 3-4 hours after

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 rendering" 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 Muscle weakness
174 – 1 2 3 Lack of Stamina
175 – 1 2 3 Drowsiness after eating
176 – 1 2 3 Muscular soreness
177 – 1 2 3 Rapid heart beat
178 – 1 2 3 Hyper-irritable
179 – 1 2 3 Feeling of a band around your head
180 – 1 2 3 Melancholia (feeling of sadness)
181 – 1 2 3 Swelling of ankles
182 – 1 2 3 Diminished urination
183 – 1 2 3 Tendency to consume sweets or carbohydrates
184 – 1 2 3 Muscle spasms
185 – 1 2 3 Blurred vision
186 – 1 2 3 Loss of muscular control
187 – 1 2 3 Numbness
188 – 1 2 3 Night sweats
189 – 1 2 3 Rapid digestion
190 – 1 2 3 Sensitivity to noise
191 – 1 2 3 Redness of palms of hands and bottom of feet
192 – 1 2 3 Visible veins on chest and abdomen
193 – 1 2 3 Hemorrhoids
194 – 1 2 3 Apprehension (feeling that something bad is going to happen)
195 – 1 2 3 Nervousness causing loss of appetite
196 – 1 2 3 Nervousness with indigestion
197 – 1 2 3 Gastritis
198 – 1 2 3 Forgetfulness
199 – 1 2 3 Thinning hair

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 before menstruation
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: _____