

# SYSTEMS SURVEY FORM

*Maestro*  
SYSTEMS SURVEY

Patient \_\_\_\_\_ Doctor \_\_\_\_\_ Date \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Approx Weight \_\_\_\_\_ Vegetarian ☐ Gluten-free ☐

**INSTRUCTIONS:** Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).

○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).

○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).

○○○ Leave circles **BLANK** if they don't apply to you!

## GROUP 1

- | 1 | 2 | 3 |   | 1                       | 2  | 3 |   | 1 | 2 | 3                                |    |   |   |   |   |                        |
|---|---|---|---|-------------------------|----|---|---|---|---|----------------------------------|----|---|---|---|---|------------------------|
| 1 | ○ | ○ | ○ | Acid foods upset        | 8  | ○ | ○ | ○ | ○ | Unable to relax; startles easily | 15 | ○ | ○ | ○ | ○ | Cold sweats often      |
| 2 | ○ | ○ | ○ | Get chilled often       | 9  | ○ | ○ | ○ | ○ | Extremities cold, clammy         | 16 | ○ | ○ | ○ | ○ | Get heated easily      |
| 3 | ○ | ○ | ○ | "Lump" in throat        | 10 | ○ | ○ | ○ | ○ | Strong light irritates           | 17 | ○ | ○ | ○ | ○ | Nerve discomfort       |
| 4 | ○ | ○ | ○ | Dry mouth-eyes-nose     | 11 | ○ | ○ | ○ | ○ | Occasionally weak urine flow     | 18 | ○ | ○ | ○ | ○ | Staring, blinks little |
| 5 | ○ | ○ | ○ | Pulse speeds after meal | 12 | ○ | ○ | ○ | ○ | Heart pounds after retiring      | 19 | ○ | ○ | ○ | ○ | Sour stomach frequent  |
| 6 | ○ | ○ | ○ | Keyed up - fail to calm | 13 | ○ | ○ | ○ | ○ | "Nervous" stomach                |    |   |   |   |   |                        |
| 7 | ○ | ○ | ○ | Gag occasionally        | 14 | ○ | ○ | ○ | ○ | Appetite reduced occasionally    |    |   |   |   |   |                        |

## GROUP 2

- | 1  | 2 | 3 |   | 1 | 2  | 3  |   | 1 | 2 | 3 |                                    |    |   |   |   |                              |
|----|---|---|---|---|--|----|---|---|---|---|------------------------------------|----|---|---|---|------------------------------|
| 20 | ○ | ○ | ○ | ○ | Joint stiffness on arising                     | 28 | ○ | ○ | ○ | ○ | Digestion rapid                    | 36 | ○ | ○ | ○ | "Slow starter"               |
| 21 | ○ | ○ | ○ | ○ | Muscle-leg-toe cramps at night                 | 29 | ○ | ○ | ○ | ○ | Vomiting occasionally              | 37 | ○ | ○ | ○ | Get "chilled"                |
| 22 | ○ | ○ | ○ | ○ | "Butterfly" stomach, cramps                    | 30 | ○ | ○ | ○ | ○ | Hoarseness frequent                | 38 | ○ | ○ | ○ | Perspire easily              |
| 23 | ○ | ○ | ○ | ○ | Eyes or nose watery                            | 31 | ○ | ○ | ○ | ○ | Uneven breathing                   | 39 | ○ | ○ | ○ | Sensitive to cold            |
| 24 | ○ | ○ | ○ | ○ | Eyes blink often                               | 32 | ○ | ○ | ○ | ○ | Pulse slow                         | 40 | ○ | ○ | ○ | Upper respiratory challenges |
| 25 | ○ | ○ | ○ | ○ | Eyelids swollen, puffy                         | 33 | ○ | ○ | ○ | ○ | Gagging reflex slow                |    |   |   |   |                              |
| 26 | ○ | ○ | ○ | ○ | Indigestion soon after meals                   | 34 | ○ | ○ | ○ | ○ | Difficulty swallowing              |    |   |   |   |                              |
| 27 | ○ | ○ | ○ | ○ | Always seems hungry; feels "lightheaded" often | 35 | ○ | ○ | ○ | ○ | Temporary constipation or diarrhea |    |   |   |   |                              |

## GROUP 3

- | 1  | 2 | 3 |   | 1 | 2                              | 3  |   | 1 | 2 | 3 |  |    |   |   |   |                                     |
|----|---|---|---|---|--------------------------------|----|---|---|---|---|--|----|---|---|---|-------------------------------------|
| 41 | ○ | ○ | ○ | ○ | Eat when nervous               | 48 | ○ | ○ | ○ | ○ | Heart palpitates if meals missed or delayed              | 52 | ○ | ○ | ○ | Crave candy or coffee in afternoons |
| 42 | ○ | ○ | ○ | ○ | Excessive appetite             | 49 | ○ | ○ | ○ | ○ | Fatigue in afternoons                                    | 53 | ○ | ○ | ○ | Moods of "blues" or melancholy      |
| 43 | ○ | ○ | ○ | ○ | Hungry between meals           | 50 | ○ | ○ | ○ | ○ | Overeating sweets upsets                                 | 54 | ○ | ○ | ○ | Craving for sweets or snacks        |
| 44 | ○ | ○ | ○ | ○ | Irritable before meals         | 51 | ○ | ○ | ○ | ○ | Awaken after few hours sleep - hard to get back to sleep |    |   |   |   |                                     |
| 45 | ○ | ○ | ○ | ○ | Get "shaky" if hungry          |    |   |   |   |   |  |    |   |   |   |                                     |
| 46 | ○ | ○ | ○ | ○ | Fatigue, eating relieves       |    |   |   |   |   |  |    |   |   |   |                                     |
| 47 | ○ | ○ | ○ | ○ | "Lightheaded" if meals delayed |    |   |   |   |   |  |    |   |   |   |                                     |

## GROUP 4

- | 1  | 2 | 3 |   | 1 | 2   | 3  |   | 1 | 2 | 3 |  |    |   |   |   |                                      |
|----|---|---|---|---|---|----|---|---|---|---|--|----|---|---|---|--------------------------------------|
| 55 | ○ | ○ | ○ | ○ | Hands and feet go to sleep easily, numbness | 62 | ○ | ○ | ○ | ○ | Get "drowsy" often   | 67 | ○ | ○ | ○ | Skin discolors easily after impact   |
| 56 | ○ | ○ | ○ | ○ | Sigh frequently, "air hunger"               | 63 | ○ | ○ | ○ | ○ | Swollen ankles, worse at night                             | 68 | ○ | ○ | ○ | Tendency to anemia                   |
| 57 | ○ | ○ | ○ | ○ | Aware of "breathing heavily"                | 64 | ○ | ○ | ○ | ○ | Muscle cramps, worse during exercise; get "charley horses" | 69 | ○ | ○ | ○ | Noises in head, or "ringing in ears" |
| 58 | ○ | ○ | ○ | ○ | High altitude discomfort                    | 65 | ○ | ○ | ○ | ○ | Difficulty catching breath especially during exercise      | 70 | ○ | ○ | ○ | Fatigue upon exertion                |
| 59 | ○ | ○ | ○ | ○ | Opens windows in closed rooms               | 66 | ○ | ○ | ○ | ○ | Tightness or pressure in chest, worse on exertion          |    |   |   |   |                                      |
| 60 | ○ | ○ | ○ | ○ | Immune system challenges                    |    |   |   |   |   |  |    |   |   |   |                                      |
| 61 | ○ | ○ | ○ | ○ | Afternoon "yawner"                          |    |   |   |   |   |  |    |   |   |   |                                      |

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## GROUP 5

- |  |   |  |
|--|---|--|
| 1 2 3<br>71 ○○○ Dizziness                          | 1 2 3<br>80 ○○○ Worrier, feels insecure     | 1 2 3<br>88 ○○○ Sneezing attacks           |
| 72 ○○○ Dry skin                                    | 81 ○○○ Nausea occasionally after eating     | 89 ○○○ Dreaming, nightmare type bad dreams |
| 73 ○○○ Burning feet                                | 82 ○○○ Greasy foods upset                   | 90 ○○○ Bad breath (halitosis)              |
| 74 ○○○ Blurred vision                              | 83 ○○○ Stools light colored                 | 91 ○○○ Milk products cause upset           |
| 75 ○○○ Itching skin and feet                       | 84 ○○○ Skin peels on foot soles             | 92 ○○○ Sensitive to hot weather            |
| 76 ○○○ Hair loss                                   | 85 ○○○ Discomfort between shoulder blades   | 93 ○○○ Burning or itching anus             |
| 77 ○○○ Occasional skin rashes                      | 86 ○○○ Occasional laxative use              | 94 ○○○ Crave sweets                        |
| 78 ○○○ Bitter, metallic taste in mouth in mornings | 87 ○○○ Stools alternate from soft to watery |  |
| 79 ○○○ Occasional constipation                     |   |  |

## GROUP 6

- |  |   |  |
|--|---|--|
| 1 2 3<br>95 ○○○ Loss of taste for meat             | 1 2 3<br>98 ○○○ Coated tongue   | 1 2 3<br>101 ○○○ Watery or loose stool |
| 96 ○○○ Lower bowel gas several hours after eating  | 99 ○○○ Pass large amounts of foul-smelling gas                              | 102 ○○○ Gas shortly after eating       |
| 97 ○○○ Burning stomach sensations, eating relieves | 100 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours after | 103 ○○○ Stomach "bloating"             |

## GROUP 7

- |   |  |  |     |
|---|--|--|-----|
| 1 2 3<br>104 ○○○ Difficulty sleeping                      | (A)                                      | 1 2 3<br>145 ○○○ Dizziness                   | (E) |
| 105 ○○○ On edge   |  | 146 ○○○ Headaches                            |     |
| 106 ○○○ Can't gain weight                                 |  | 147 ○○○ Hot flashes                          |     |
| 107 ○○○ Intolerance to heat                               | 1 2 3<br>(C)                             | 148 ○○○ Hair growth on face or body (female) |     |
| 108 ○○○ Highly emotional                                  | 134 ○○○ Failing memory with age          | 149 ○○○ Sugar in urine (not diabetes)        |     |
| 109 ○○○ Flush easily                                      | 135 ○○○ Increased sex drive              | 150 ○○○ Masculine tendencies (female)        |     |
| 110 ○○○ Night sweats                                      | 136 ○○○ Episodes of tension in head      |  |     |
| 111 ○○○ Thin, moist skin                                  | 137 ○○○ Decreased sugar tolerance        |  |     |
| 112 ○○○ Inward trembling                                  |  |  |     |
| 113 ○○○ Heart races                                       |  |  |     |
| 114 ○○○ Increased appetite without weight gain            |  |  |     |
| 115 ○○○ Pulse fast at rest                                | 1 2 3<br>(D)                             | 1 2 3<br>(F)                                 |     |
| 116 ○○○ Eyelids and face twitch                           | 138 ○○○ Abnormal thirst                  | 151 ○○○ Weakness, dizziness                  |     |
| 117 ○○○ Irritable and restless                            | 139 ○○○ Bloating of abdomen              | 152 ○○○ Tired throughout day                 |     |
| 118 ○○○ Can't work under pressure                         | 140 ○○○ Weight gain around hips or waist | 153 ○○○ Nails weak, ridged                   |     |
| 1 2 3<br>(B)  | 141 ○○○ Sex drive reduced or lacking     | 154 ○○○ Sensitive skin                       |     |
| 119 ○○○ Increase in weight                                | 142 ○○○ Tendency for stomach issues      | 155 ○○○ Stiff joints                         |     |
| 120 ○○○ Decrease in appetite                              | 143 ○○○ Increased sugar tolerance        | 156 ○○○ Perspiration increase                |     |
| 121 ○○○ Fatigue easily                                    | 144 ○○○ Menstrual disorders              | 157 ○○○ Bowel discomfort                     |     |
| 122 ○○○ Ringing in ears                                   |  | 158 ○○○ Poor circulation                     |     |
| 123 ○○○ Sleepy during day                                 |  | 159 ○○○ Swollen ankles                       |     |
| 124 ○○○ Sensitive to cold                                 |  | 160 ○○○ Crave salt                           |     |
| 125 ○○○ Dry or scaly skin                                 |  | 161 ○○○ Areas of skin darkening              |     |
| 126 ○○○ Temporary constipation                            |  | 162 ○○○ Upper respiratory sensitivity        |     |
| 127 ○○○ Mental sluggishness                               |  | 163 ○○○ Tiredness                            |     |
| 128 ○○○ Hair coarse, falls out                            |  | 164 ○○○ Breathing challenges                 |     |
| 129 ○○○ Tension in head upon arising wears off during day |  |  |     |
| 130 ○○○ Slow pulse, below 65                              |  |  |     |
| 131 ○○○ Changing urinary function                         |  |  |     |
| 132 ○○○ Sounds appear diminished                          |  |  |     |
| 133 ○○○ Reduced initiative                                |  |  |     |

# SYSTEMS SURVEY FORM - PAGE 3

## GROUP 8

1	2	3		1	2	3		1	2	3	
165	<input type="radio"/>	<input type="radio"/>	Muscle weakness	175	<input type="radio"/>	<input type="radio"/>	Tendency to consume sweets or carbohydrates	184	<input type="radio"/>	<input type="radio"/>	Visible veins on chest and abdomen
166	<input type="radio"/>	<input type="radio"/>	Lack of Stamina	176	<input type="radio"/>	<input type="radio"/>	Muscle spasms	185	<input type="radio"/>	<input type="radio"/>	Hemorrhoids
167	<input type="radio"/>	<input type="radio"/>	Drowsiness after eating	177	<input type="radio"/>	<input type="radio"/>	Blurred vision	186	<input type="radio"/>	<input type="radio"/>	Apprehension (feeling that something bad will happen)
168	<input type="radio"/>	<input type="radio"/>	Muscular soreness	178	<input type="radio"/>	<input type="radio"/>	Involuntary muscle action	187	<input type="radio"/>	<input type="radio"/>	Nervousness causing loss of appetite
169	<input type="radio"/>	<input type="radio"/>	Heart races	179	<input type="radio"/>	<input type="radio"/>	Numbness	188	<input type="radio"/>	<input type="radio"/>	Nervousness with indigestion
170	<input type="radio"/>	<input type="radio"/>	Hyper-irritable	180	<input type="radio"/>	<input type="radio"/>	Night sweats	189	<input type="radio"/>	<input type="radio"/>	Gastritis
171	<input type="radio"/>	<input type="radio"/>	Feeling of a band around your head	181	<input type="radio"/>	<input type="radio"/>	Rapid digestion	190	<input type="radio"/>	<input type="radio"/>	Forgetfulness
172	<input type="radio"/>	<input type="radio"/>	Melancholia (feeling of sadness)	182	<input type="radio"/>	<input type="radio"/>	Sensitivity to noise	191	<input type="radio"/>	<input type="radio"/>	Thinning hair
173	<input type="radio"/>	<input type="radio"/>	Swelling of ankles	183	<input type="radio"/>	<input type="radio"/>	Redness of palms of hands and bottom of feet				
174	<input type="radio"/>	<input type="radio"/>	Change in urinary function								

## FEMALE ONLY

1	2	3		1	2	3	
192	<input type="radio"/>	<input type="radio"/>	Very easily fatigued	197	<input type="radio"/>	<input type="radio"/>	Menstruate too frequently
193	<input type="radio"/>	<input type="radio"/>	Premenstrual tension	198	<input type="radio"/>		Hysterectomy / ovaries removed
194	<input type="radio"/>	<input type="radio"/>	Menses more painful than usual	199	<input type="radio"/>	<input type="radio"/>	Menopausal hot flashes
195	<input type="radio"/>	<input type="radio"/>	Depressed feelings before menstruation	200	<input type="radio"/>	<input type="radio"/>	Menses scanty or missed
196	<input type="radio"/>	<input type="radio"/>	Painful breasts during menses	201	<input type="radio"/>	<input type="radio"/>	Acne, worse at menses

## MALE ONLY

1	2	3	
202	<input type="radio"/>	<input type="radio"/>	Less involved in exercise/social activities
203	<input type="radio"/>	<input type="radio"/>	Difficult to postpone urination
204	<input type="radio"/>	<input type="radio"/>	Weak urinary stream
205	<input type="radio"/>	<input type="radio"/>	Feeling of "blues" or melancholy
206	<input type="radio"/>	<input type="radio"/>	Feeling of incomplete bowel evacuation
207	<input type="radio"/>	<input type="radio"/>	Lack of energy
208	<input type="radio"/>	<input type="radio"/>	Muscles in arms and legs seem softer/smaller
209	<input type="radio"/>	<input type="radio"/>	Tire too easily
210	<input type="radio"/>	<input type="radio"/>	Avoids activity
211	<input type="radio"/>	<input type="radio"/>	Leg nervousness at night
212	<input type="radio"/>	<input type="radio"/>	Diminished sex drive

## IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## 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

## RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.

## SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking:

☐ No Medications

Please list any vitamins, herbs, or supplements you are taking:

☐ No Vitamins

Please list any allergies you have:

☐ No Allergies

Please list any surgeries you have had in the past 12 months:

☐ No Recent Surgeries

Please list any other surgeries or medical procedures you have had:

☐ No Other Surgeries

### TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent \_\_\_\_\_ Standing \_\_\_\_\_

Pulse: Recumbent \_\_\_\_\_ Standing \_\_\_\_\_

Hema-Combistix Urine Readings: pH \_\_\_\_\_ Albumin % \_\_\_\_\_ Glucose % \_\_\_\_\_

Occult Blood \_\_\_\_\_ pH of Saliva \_\_\_\_\_ pH of Stool Specimen \_\_\_\_\_

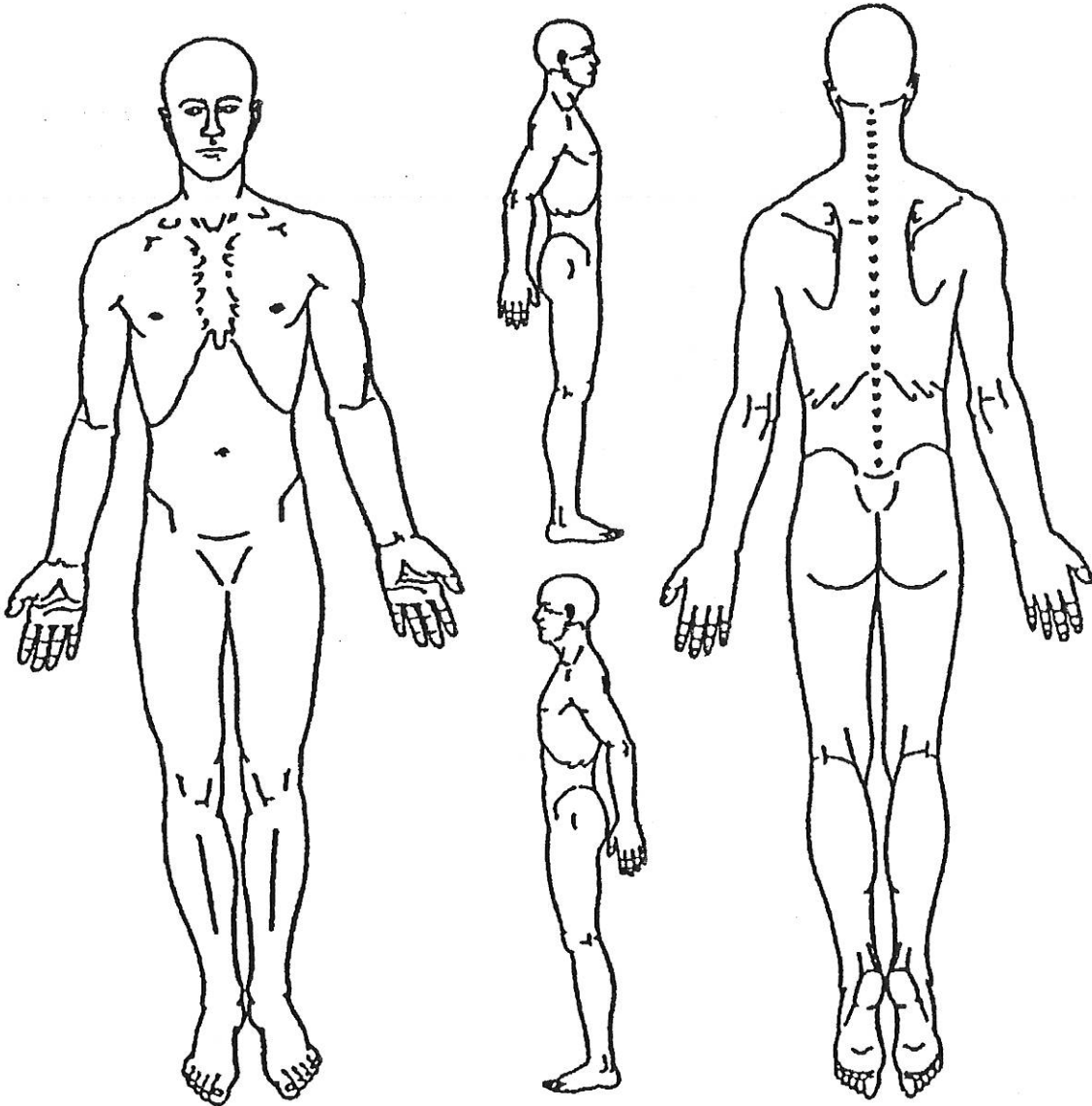
Blood Clotting Time \_\_\_\_\_ Hemoglobin \_\_\_\_\_ Blood Type \_\_\_\_\_ Weight \_\_\_\_\_

## SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

### KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_