

NEW MOON  
FAMILY ACUPUNCTURE  
ANCIENT MEDICINE FOR THE MODERN FAMILY

New Moon Family Acupuncture has relocated to the

NEW MOON  
FAMILY WELLNESS CENTER

906 South Cowley  
Spokane, WA 99203

Cowley is located Northeast of Sacred Heart, on the same street as St. Luke's rehab and Inland Imaging. The center is on the NW corner of 9th and Cowley. It is red brick building with a ramp in front.



ANCIENT MEDICINE FOR THE MODERN FAMILY

## Welcome to Our Community Clinic

### Why We Treat in a Community Setting

Most US acupuncturists treat patients on tables in individual cubicles. This is not traditional in Asia, where acupuncture usually occurs in a community setting. In our clinic we use recliners and tables in a large, quiet, soothing space. Treating patients in a community setting has many benefits: it's easy for friends and family members to receive treatment together and many find it comforting as the collective energetic field (group chi) nurtures the entire group. In some styles of acupuncture, the needles are removed after only a few minutes or after a half hour at most. The style of acupuncture practiced at the New Moon Family Acupuncture allows you to receive treatment for as long as you want. Most people learn to sense when the treatment is "done". This can vary from 20 minutes to an hour or more. Many people fall asleep, and wake feeling refreshed.

### We Have a Sliding Scale

Most US acupuncturists see one or two patients per hour and charge \$65 to \$175 per treatment. They tend to spend a long time talking with each patient, going over medical records, asking many questions. We don't. In order to make acupuncture affordable for you and still make a living, we streamline our treatments and see multiple patients per hour. Instead of asking lots of questions, we rely on our diagnostic skills to treat you. This is exactly how acupuncture is traditionally practiced in Asia -- many patients per hour and very little talking.

High quality acupuncture in a community atmosphere at affordable rates (\$15 minimum) – that's the goal of New Moon Family Acupuncture's Community Clinic. We practice a blend of acupuncture styles, mostly relying upon "distal" points in the hands, feet and head to treat problems anywhere in the body. Research in the United States (as well as thousands of years of tradition in Asia) has shown that acupuncture is most effective when it is done frequently and regularly – once a week is usually the minimum required to make progress on any kind of health issue. The purpose of our sliding scale is to separate the issues of money and treatment; we want you to come in often enough to really get better and stay better! Because we have a sliding scale, we cannot do insurance billing (that's the insurance companies' rule). If you have insurance that covers acupuncture, we'll be happy to provide a payment receipt, and you may then submit it. New Moon Family Acupuncture does not receive grants, state or federal money, or insurance reimbursement. New Moon Family Acupuncture exists because patients pay for their treatments – it is a sustainable community business model.

### What We Need From You

#### Medical Responsibility

New Moon Family Acupuncture does not provide primary care medicine! Acupuncture is an excellent complement to Western medicine, but it is not a substitute for it. If you have, or think you may have a potentially serious condition such as an infection, unexplained weight loss or gain, heart conditions, suspected fracture or dislocation, severe abdominal pain, respiratory distress, serious bleeding, brain disorders, etc. you need to be under the care of a physician (ND, MD, or DO) for us to treat you in accordance with Washington state law. We can provide complimentary care for many of these conditions—for instance, acupuncture treats the side effects of chemotherapy very effectively, as well as being of great value in stroke rehabilitation. However, acupuncture is not primary care medicine.

# NEW MOON

## FAMILY ACUPUNCTURE

ANCIENT MEDICINE FOR THE MODERN FAMILY

### **Flexibility**

The community setting requires some flexibility from you. For instance, many patients have a favorite recliner or table. When the clinic is busy, someone may be sitting in yours. Similarly, we may have a few patients who snore. Other patients who dislike snoring bring earplugs to their treatments. We are grateful for this! Some people even bring a pillow or blanket from home, because they prefer theirs to ours. That's fine with us. Basically, we need you to make yourself comfortable in the community room before we arrive to treat you. Let us know at the beginning of the treatment, if you need to be somewhere at a certain time or if you want to be unpinned after a specific amount of time. We'll make sure you're out on time. In general, if you feel "done", open your eyes and give us a meaningful look—if your eyes are closed, we'll think you're asleep and we won't wake you up.

### **Community-Mindedness**

The soothing atmosphere in our clinic exists because all of our patients create it by relaxing together. We appreciate everyone's presence! Such collective stillness is rare and precious in our rushed society. Maintaining this reservoir of calm requires that no one talk very much in the clinic space, and that they speak softly in the waiting area. If you would like to speak to a practitioner one-on-one at any length, please let us know. We may need to schedule it separately and might need to do it by phone. When you walk through the treatment space, please move slowly and quietly. If you have questions about acupuncture and how it works—please visit our website or email us. Unfortunately, we can't explain what every point does, or how acupuncture works, while we are treating you—these are very large topics! We will also have gatherings periodically where we can meet and engage in question/answer sessions and explore topics of interest.

### **A Little Help Running the Clinic**

Our mission is to serve as many people as we can in the community, however, our budget is small. Therefore, we do not have a receptionist and we need your help so that the clinic runs smoothly: Payment happens on the honor system. Please pay for your treatment before entering the treatment area by inserting cash or check into one of the envelopes provided and then inserting it into the box. If you need a receipt, please write your name on the envelope and fill out a receipt from the receipt pad provided. Please take all personal belongings with you back into the treatment room. We cannot be responsible for items left in the waiting room. And of course, please turn off your cell phone or pager. If you are able, please use our online scheduling system by going to our website. This service is easy to use and it frees up our time to give more acupuncture treatments. If you need to speak with one of us to schedule appointments and we are busy with patients, please leave us a note with a list of times that work for you, or leave us a phone message.

### **Commitment**

Acupuncture is a PROCESS. It is unrealistic to expect your problem to resolve after one treatment. In China, a typical treatment protocol for a chronic condition could be acupuncture every other day for three months! Most people don't require that much acupuncture, but virtually every patient requires a course of treatment, which can vary in length and frequency. We are able to keep our prices so low, in part because of the extraordinary amount of marketing our patients do on our behalf - we do very little advertising. We cannot express how grateful we are for this. Our patients are such effective marketers because they have first-hand experience of how well acupuncture works. Our satisfied patients basically made a commitment to a course of treatment. On your first visit, your acupuncturist will suggest a course of treatment, which can be anything from "we'd like to see you once a week for six weeks" to "we'd really like to see you every day for the next four days". This suggestion is based on our experience with treating different kinds of conditions. If you don't come in often enough or long enough, acupuncture probably won't work for you. The purpose of our sliding scale is to help you make that commitment. If you have questions about how long it will take to see results, please ask us, or if you think you need to adjust your treatment plan, please let us know. We need you to commit to the process of treatment in order to get good results.



ANCIENT MEDICINE FOR THE MODERN FAMILY

## Financial and Cancellation Policies

New Moon Family Acupuncture makes every attempt to provide acupuncture to as many people as possible by implementing a fair sliding scale policy. The fee range is \$20 – \$40, pay what you can. In addition, there is a one-time \$10 administrative fee for paperwork and registration.

We recognize that life sometimes gets in the way of one's commitments. If you need to cancel or reschedule your appointment, we ask that you do so at least 24 hours before your original appointment. All appointments that are cancelled or rescheduled with less than 24 hour advance notice, or appointments missed without notice, will be charged the regular fee for that appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

We thank you for your understanding,  
The *New Moon Acupuncture* Staff

---

SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN (INCLUDING RELATIONSHIP)

---

DATE

---

PRINTED NAME OF THE ABOVE SIGNED

## Informed Consent for Acupuncture

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Rebekah Giangreco, Licensed Acupuncturist (Lic#WA00002022), and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Rebekah Giangreco, including those working at New Moon Family Acupuncture or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs or nutritional supplements.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN (INCLUDING RELATIONSHIP)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF THE ABOVE SIGNED

## Health History Questionnaire

Please take the time to accurately fill out this form; all information provided will help guide our treatment strategy. Feel free to ask questions, all information provided will be kept confidential.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Best number to leave a message: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact In case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Please identify your primary health concerns in the order of severity:

Health Concern	Onset	Known Cause	Previous Treatment(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What do you hope to accomplish by seeking out treatment with acupuncture and oriental medicine?

\_\_\_\_\_

To what extents do the health concerns affect your daily activities (work, sleep, sex...)?

\_\_\_\_\_

\_\_\_\_\_

If you have been given a diagnosis for your health concern(s), please describe the diagnoses below and indicate who made the diagnosis.

\_\_\_\_\_

Please list any therapies you are currently utilizing to remedy your condition. Include prescription and other medications if applicable.

\_\_\_\_\_

\_\_\_\_\_

# NEW MOON

## FAMILY ACUPUNCTURE

ANCIENT MEDICINE FOR THE MODERN FAMILY

**Please list all other medications or supplements you have taken over the last three months:**

Medication/supplement	Reason for taking	Dosage/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family Medical History**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma _____        | <input type="checkbox"/> Hepatitis _____           | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> STD's _____    |
| <input type="checkbox"/> Diabetes _____      | <input type="checkbox"/> HIV _____                 | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic Fever _____     |   |

**Personal Medical History**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma _____        | <input type="checkbox"/> Hepatitis _____           | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> STD's _____    |
| <input type="checkbox"/> Diabetes _____      | <input type="checkbox"/> HIV _____                 | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic Fever _____     |   |

**Gynecological History**

Age of first period: \_\_\_\_\_ Date of Last Period: \_\_\_/\_\_\_/\_\_\_ Current Contraception: \_\_\_\_\_  
 Are you currently pregnant?  Yes  No  Maybe Due Date \_\_\_\_\_  
 Age Peri-menopause began: \_\_\_\_\_ Ended: \_\_\_\_\_  
 Are you on Hormone Replacement Therapy? \_\_\_\_\_  
 Other gynecological information: \_\_\_\_\_

**Are any of the following applicable to you?**

- Surgeries – types and date (s): \_\_\_\_\_
- Significant Trauma – auto accidents, falls, etc.: \_\_\_\_\_
- Significant Dental Work – types and date (s): \_\_\_\_\_
- Occupational Stress – Chemical, physical, psychological: \_\_\_\_\_
- Your Birth history (forceps, prolonged labor, twin, premature): \_\_\_\_\_
- Childhood illnesses (anything predominant – measles, mumps, chickenpox): \_\_\_\_\_
- Vaccination history: \_\_\_\_\_

Please describe your exercise program: \_\_\_\_\_

Do you have allergies (drug, food, chemical, airborne, etc.)? \_\_\_\_\_

Please describe reactions: \_\_\_\_\_

# NEW MOON

FAMILY ACUPUNCTURE

ANCIENT MEDICINE FOR THE MODERN FAMILY

**Habits – please indicate usage per day/week/year**

Cigarettes: \_\_\_\_\_ Per \_\_\_\_\_

Sugar: \_\_\_\_\_ Per \_\_\_\_\_

Coffee: \_\_\_\_\_ Per \_\_\_\_\_

Tea: \_\_\_\_\_ Per \_\_\_\_\_

Cola: \_\_\_\_\_ Per \_\_\_\_\_

Drugs: \_\_\_\_\_ Per \_\_\_\_\_

Alcohol: \_\_\_\_\_ Per \_\_\_\_\_

Other: \_\_\_\_\_ Per \_\_\_\_\_

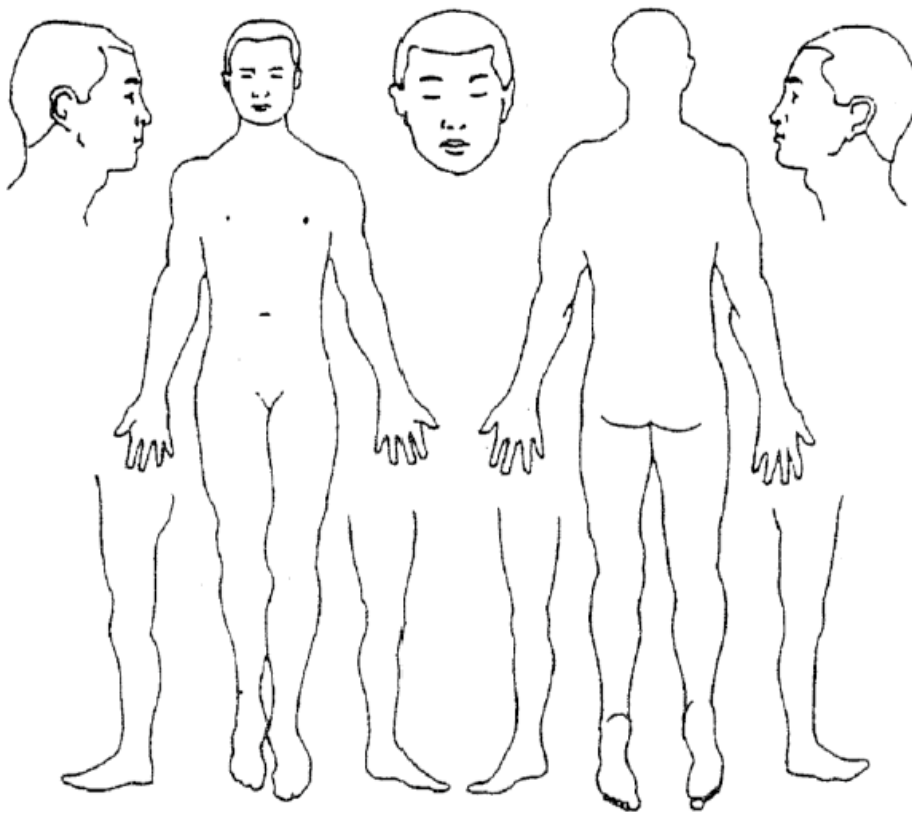
**Please describe your average daily diet/routine:**

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

**Indicate painful or distressed areas below:**



**SYMPTOM SURVEY FORM**  
(Restricted to Professional Use)

PATIENT \_\_\_\_\_ DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_ VEGETARIAN \_\_\_ Yes \_\_\_ No

**INSTRUCTIONS:** Circle the number that applies to you. If symptom doesn't apply, leave blank. Use (1) for MILD symptoms (occurs once or twice a month), (2) for MODERATE symptoms (occurs several times a month), and (3) for SEVERE symptoms (you are aware of it almost constantly).

**GROUP ONE**

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

**GROUP TWO**

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

**GROUP THREE**

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

**GROUP FOUR**

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

**SYMPTOM SURVEY FORM – Page 2**

**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 1/2- 1 hour after eating; may be up to 3 - 4 hrs. | 106 - 1 2 3 Stomach "bloating" after eating     |

**GROUP SEVEN**

- |  |   |  |
|--|---|--|
| <b>(A)</b>   |   | <b>(E)</b>                                       |
| 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                               | <b>(C)</b>  | 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                      | <b>(F)</b>                                       |
| 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                     | <b>(D)</b>  | 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                 |
|  | 143 - 1 2 3 Bloating of abdomen                     | 163 - 1 2 3 Perspiration increase                |
| <b>(B)</b>   | 144 - 1 2 3 Weight gain around hips or waist        | 164 - 1 2 3 Bowel disorders                      |
| 122 - 1 2 3 Increase in weight                         | 145 - 1 2 3 Sex drive reduced or lacking            | 165 - 1 2 3 Poor circulation                     |
| 123 - 1 2 3 Decrease in appetite                       | 146 - 1 2 3 Tendency to ulcers, colitis             | 166 - 1 2 3 Swollen ankles                       |
| 124 - 1 2 3 Fatigue easily                             | 147 - 1 2 3 Increased sugar tolerance               | 167 - 1 2 3 Crave salt                           |
| 125 - 1 2 3 Ringing in ears                            | 148 - 1 2 3 Women: menstrual disorders              | 168 - 1 2 3 Brown spots or bronzing of skin      |
| 126 - 1 2 3 Sleepy during day                          | 149 - 1 2 3 Young girls: lack of menstrual function | 169 - 1 2 3 Allergies – tendency to asthma       |
| 127 - 1 2 3 Sensitive to cold                          |   | 170 - 1 2 3 Weakness after colds, influenza      |
| 128 - 1 2 3 Dry or scaly skin                          |   | 171 - 1 2 3 Exhaustion – muscular and nervous    |
| 129 - 1 2 3 Constipation                               |   | 172 - 1 2 3 Respiratory disorders                |
| 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                           |   |  |

**SYMPTOM SURVEY FORM – Page 3**

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:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

(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: \_\_\_\_\_

BP SIT \_\_\_\_\_ BP STAND \_\_\_\_\_

PULSE SIT \_\_\_\_\_ PULSE STAND \_\_\_\_\_

SALIVA PH \_\_\_\_\_ BLOOD TYPE \_\_\_\_\_