TENNESSEE VALLEY CLINIC OF CHIROPRACTIC

304 FIRST AVE ❁ DAYTON, TN 37321 ❁ 423-775-6688 PHONE ❁ 423-775-8777 FAX

PLEASE PRINT

PERSONAL INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____CITY: _____

STATE: _____ ZIP: _____ E-MAIL: _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

GENDER: **MALE** **FEMALE** MARITAL STATUS: **S M D W** NUMBER OF CHILDREN: _____

REFERRED BY_____

EMPLOYER: _____OCCUPATION: _____ PHONE:_ _____

ADDRESS_____CITY: _____ STATE: _____ ZIP_____

NAME OF SPOUSE (OR PARENT)_____DATE OF BIRTH:_____

OCCUPATION/EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

MEDICARE? ___YES ___NO

EMERGENCY NOTIFICATION

NAME _____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT_____

HOW DID IT HAPPEN?_____

_____

TODAY'S CONDITION STARTED WHEN?_____

IS YOUR CONDITION DUE TO AN ACCIDENT? ___YES ___NO DATE OF ACCIDENT: _____

TYPE OF ACCIDENT? AUTO _____ WORK/ON JOB _____ AT HOME _____ OTHER _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION?_____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

ARE THERE ANY OTHER SYMPTOMS OR CONDITIONS YOU HAVE THAT MAY BE RELATED TO TODAY'S CONDITION?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

TYPE OF TREATMENT_____RESULTS_____

HOSPITALIZATIONS

DATE:	REASON:

MEDICAL HISTORY

1 = HAVE
2 = HAD

(*MARK BOX WITH **1** IF YOU HAVE THE SYMPTOM OR **2** IF YOU'VE HAD THE SYMPTOM IN THE PAST*)

__ABDOMINAL PAIN – CHRONIC
__ANEMIA
__APPENDICITUS
__ARTHRITIS/RHEUMATISM
__ASTHMA/WHEEZING
__BACK OR NECK PAIN – RECURRENT
__BACK OR NECK STIFFNESS
__BED-WETTING
__BELCHING OR GAS
__BLOATING
__BLOODY OR TARRY STOOLS
__BLOOD IN URINE
__BONE FRACTURE/JOINT INJURY
__BRONCHITIS/CHRONIC COUGH
__BRUISE EASILY
__BURSITIS
__CANCER
__CHANGE IN BOWEL HABITS
__CHEST PAIN
__CHROHN'S/COLITIS
__CHRONIC FATIGUE
__COLD/NUMB EXTREMITIES
__CONSTIPATION
__CONVULSIONS/SEIZURES
__COPD
__DEAFNESS
__DEPRESSION
__DIABETES
__DIARRHEA
__DIFFICULT DIGESTION
__DIFFICULTY SWALLOWING
__DIVERTICULITIS/CROHNS/COLITIS
__DIZZINESS/BALANCE
__EAR INFECTIONS
__EYE INFECTIONS - FREQUENT
__EYE PAIN
__FAILING VISION
__FAINTING
__FEVER
__GALL BLADDER TROUBLE
__GLUTEN
__GOUT
__HAYFEVER/ALLERGIES
__HEADACHES – FREQUENT
__HEART MURMUR
__HEART PALPITATIONS
__HEART/BLOOD VESSEL DISEASE
__HEMORRHOIDS
__HERNIA
__HIGH BLOOD PRESSURE
__INDEGESTION OR HEARTBURN
__INFECTIONS-FREQUENT
__ITCHING/DRYNESS
__JAUNDICE/HEPATITIS
__JOINT PAIN/STIFFNESS/SWELLING
__KIDNEY STONES
__LACTOSE INTOLERANCE
__LEG PAIN – WALKING
__LOSS OF APPETITE
__LOW BLOOD PRESSURE
__LUPUS
__MEMORY LOSS
__MENTAL ILLNESS
__MOODINESS-EXCESSIVE
__MULTIPLE SCLEROSIS
__MUSCLE WEAKNESS
__NERVOUSNESS/ANXIETY
__NEUROPATHY(BURNING IN FEET/HANDS)
__NOSE BLEEDS
__NUMBNESS/TINGLING SENSATIONS
__OSTEOPOROSIS
__PAIN GOING DOWN ARMS
__PAIN GOING DOWN LEGS
__PHOBIAS
__PAINFUL TAIL BONE
__PEPTIC ULCERS
__PERISTANT NAUSEA/VOMITING
__PNEMONIA
__POOR CIRCULATION
__PROSTATE DISEASE
__PSORIASIS/ECZEMA
__RAPID HEART BEAT
__RASHES/HIVES
__RINGING IN EARS
__SEXUAL/MENSTRUAL DYSFUNCTION
__SHINGLES
__SHORTNESS OF BREATH
__SINUS TROUBLE
__SORE THROAT – FREQUENT
__STROKE
__SWEATS
__SWELLING
__SWOLLEN ANKLES
__SWOLLEN TONSILS/GLANDS
__THYROID DISEASE
__TREMOR/HANDS SHAKING
__URETHRAL DISCHARGE
__URINE INFECTION
__FREQUENTURINATION
  __OVERNIGHT <TWICE
  __PAINFUL
  __LOSS OF CONTROL
  __DECREASE IN FORCE/FLOW
__VARICOSE VEINS
__VENEREAL DISEASE
__WEIGHT LOSS – RECENT
__WHOOPING COUGH
__OTHER_____
__OTHER_____

CONTINUE...
__DIPTHERIA
__TETANUS
__CHICKEN POX POLIO MUMPS
__MEASLES
__RUBELLA
__RHEUMATIC FEVER
__SCARLET FEVER
__TUBERCULOSIS
__HERPES
__OTHER_____
__
OTHER_____
_____

HABITS
__ ALCOHOL: TYPE _____ AMOUNT _____
__ SMOKING: PACKS DAILY _____ HOW LONG? _____
__INTERESTED IN STOPPING? _____
__ CAFFEINE: COFFEE, CUPS DAILY? _____ OTHER _____
__ EXERCISE ROUTINE (PLEASE EXPLAIN) _____
_____

SLEEP (*PLEASE CHECK ALL THAT APPLY*)
__ DIFFICULTY FALLING ASLEEP __CONTINUITY DISTURBANCES
__ EARLY MORNING AWAKENINGS __DAYTIME DROWSINESS
OTHER:_____

NUMBER OF:
PREGNANCIES _____
ABORTIONS _____
MISCARRIAGES _____
LIVE BIRTHS _____

*ARE YOU VEGETARIAN ❑YES ❑NO

FEMALES- PLEASE COMPLETE
ARE YOU PREGNANT?❑YES ❑NO
PLANNING PREGNANCY? ❑YES ❑NO
MENSTRUAL FLOW ❑REGULAR ❑IRREGULAR ❑PAIN/CRAMPS ❑FLUSHING ❑MENOPAUSE
LENGTH OF CYCLE?_____
1ST DAY OF LAST PERIOD?_____
DO YOU EXPERIENCE PAIN/BLEEDING DURING OR AFTER INTERCOURSE?❑YES ❑NO
BIRTH CONTROL METHOD? (*LIST ANY MEDICATIONS*)_____
DATE OF LAST PAP TEST? _____ ❑ NORMAL ❑ ABNORMAL

DATE OF LAST MAMMOGRAM? _____ ❑ NORMAL ❑ ABNORMAL

Systems Survey Form | Restricted to Professional Use

Standard Process®

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS:
Circle the number that applies to you.
If a symptom does not apply, or if your symptom is mild do not circle anything for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely) ***DO NOT CIRCLE***
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

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 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

___ ___ ___ TOTAL
1 2 3

GROUP 2

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

___ ___ ___ TOTAL
1 2 3

GROUP 3

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

___ ___ ___ TOTAL
1 2 3

GROUP 4

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

___ ___ ___ TOTAL
1 2 3

GROUP 5

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

___ ___ ___ TOTAL
1 2 3

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

___ ___ ___ TOTAL
1 2 3

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

___ ___ ___ TOTAL
1 2 3

GROUP 7B

119.	1	2	3	Increase in weight
120.	1	2	3	Decrease in appetite
121.	1	2	3	Fatigue easily
122.	1	2	3	Ringing in ears
123.	1	2	3	Sleepy during day
124.	1	2	3	Sensitive to cold
125.	1	2	3	Dry or scaly skin
126.	1	2	3	Temporary constipation
127.	1	2	3	Mental sluggishness
128.	1	2	3	Hair coarse, falls out
129.	1	2	3	Tension in head upon arising wears off during day
130.	1	2	3	Slow pulse below 65
131.	1	2	3	Changing urinary function
132.	1	2	3	Sounds appear diminished
133.	1	2	3	Reduced initiative

____ ____ ____ TOTAL
1 2 3

GROUP 7C

134.	1	2	3	Failing memory with age
135.	1	2	3	Increased sex drive
136.	1	2	3	Episodes of tension in head
137.	1	2	3	Decreased sugar tolerance

____ ____ ____ TOTAL
1 2 3

GROUP 7D

138.	1	2	3	Abnormal thirst
139.	1	2	3	Bloating of abdomen
140.	1	2	3	Weight gain around hips or waist
141.	1	2	3	Sex drive reduced or lacking
142.	1	2	3	Tendency for stomach issues
143.	1	2	3	Immune system challenges
144.	1	2	3	Menstrual disorders

____ ____ ____ TOTAL
1 2 3

GROUP 7E

145.	1	2	3	Dizziness
146.	1	2	3	Headaches
147.	1	2	3	Hot flashes
148.	1	2	3	Hair growth on face or body (female)
149.	1	2	3	Sugar in urine (not diabetes)
150.	1	2	3	Masculine tendencies (female)

____ ____ ____ TOTAL
1 2 3

GROUP 7F

151.	1	2	3	Weakness, dizziness
152.	1	2	3	Tired throughout day
153.	1	2	3	Nails weak, ridged
154.	1	2	3	Sensitive skin
155.	1	2	3	Stiff joints
156.	1	2	3	Perspiration increase
157.	1	2	3	Bowel discomfort
158.	1	2	3	Poor circulation
159.	1	2	3	Swollen ankles
160.	1	2	3	Crave salt
161.	1	2	3	Areas of skin darkening
162.	1	2	3	Upper respiratory sensitivity
163.	1	2	3	Tiredness
164.	1	2	3	Breathing challenges

____ ____ ____ TOTAL
1 2 3

GROUP 8

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

____ ____ ____ TOTAL
1 2 3

FEMALE ONLY

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

____ ____ ____ TOTAL
1 2 3

MALE ONLY

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

____ ____ ____ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion

_____ Hydrochloric Acid Point

_____ Enzyme Point

_____ Murphy's Sign

Large Intestine (Palpate)

_____ Ascending

_____ Transverse

_____ Descending

Adrenals

Pass/Fail Pupil Dilation Exam

Postural Hypotension

_____ Supine

_____ Standing

Pass/Fail Zinc Taste Test

Pass/Fail Cuff Test

_____ Cuff Pressure

_____ pH of Saliva

_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning 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 such as 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 second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. 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 intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.