MCKINZIE CHIROPRACTIC & NUTRITION

www.DrMcKinzie.com

Patient Symptom Survey Form

Attached is a comprehensive survey form to evaluate an individual's nutritional deficiencies.

The food Americans eat is lacking vital nutrients. Modern technology and a fast-paced world have caused us to increasingly eat on the run, eat too much, and eat unhealthy, highly processed GMO foods laden with sugar and fat. At the same time, Americans don't exercise as much which is leading to an ever increasing number of people who develop serious diseases.

What can we do?

- **First, find out what nutrients your body is deficient in and begin a period of healing to rebuild your body**
- **Supplement daily with a whole food supplements proven to improve health**
- **Consider a period of cleansing for your body to flush out toxins and waste**
- **Consider the physical and emotional aspects of your life and address any issues that affect your health.**

Use some "*good ole common sense*" and make better lifestyle choices which includes concentrated whole-food supplements, not isolated, synthetically manufactured vitamins.

The attached survey will address vitamin deficiencies, sympathetic and parasympathetic overload, blood sugar stress, cardiovascular health, liver and gallbladder health, digestive stress, thyroid imbalances, pituitary imbalances, adrenal imbalances, as well as male and female hormone imbalances.

Please read the instructions carefully.

Return the survey form to:
Dr. Lonny R. McKinzie
3600 Old Bullard Rd, Ste. 350
Tyler, TX. 75701
or Fax to 903-787-8847

Be sure to include your phone number and email address (if you have one) so I can contact you with your results.

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"Improving your health with functional medicine!"

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male .. Female ..

Pulse: Recumbent _____ Standing _____ Vegetarian .. Gluten-free ..

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ..

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurs rarely).
○ ● ○ MODERATE symptoms (occurs several times a month).
○ ○ ● SEVERE symptoms (occurs almost constantly)
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Gag occasionally
8	○	○	○	Unable to relax; startles easily
9	○	○	○	Extremities cold, clammy
10	○	○	○	Strong light irritates
11	○	○	○	Occasionally weak urine flow
12	○	○	○	Heart pounds after retiring
13	○	○	○	"Nervous" stomach
14	○	○	○	Appetite reduced occasionally
15	○	○	○	Cold sweats often
16	○	○	○	Get heated easily
17	○	○	○	Nerve discomfort
18	○	○	○	Staring, blinks little
19	○	○	○	Sour stomach frequent
				GROUP 2
20	○	○	○	Joint stiffness on arising
21	○	○	○	Muscle-leg-toe cramps at night
22	○	○	○	"Butterfly" stomach, cramps
23	○	○	○	Eyes or nose watery
24	○	○	○	Eyes blink often
25	○	○	○	Eyelids swollen, puffy
26	○	○	○	Indigestion soon after meals
27	○	○	○	Always seems hungry; feels "lightheaded" often
28	○	○	○	Digestion rapid
29	○	○	○	Vomiting occasionally
30	○	○	○	Hoarseness frequent
31	○	○	○	Uneven breathing
32	○	○	○	Pulse slow
33	○	○	○	Gagging reflex slow
34	○	○	○	Difficulty swallowing
35	○	○	○	Temporary constipation or diarrhea
36	○	○	○	"Slow starter"
37	○	○	○	Get "chilled"
38	○	○	○	Perspire easily
39	○	○	○	Sensitive to cold
40	○	○	○	Upper respiratory challenges
				GROUP 3
41	○	○	○	Eat when nervous
42	○	○	○	Excessive appetite
43	○	○	○	Hungry between meals
44	○	○	○	Irritable before meals
45	○	○	○	Get "shaky" if hungry
46	○	○	○	Fatigue, eating relieves
47	○	○	○	"Lightheaded" if meals delayed
48	○	○	○	Heart palpitates if meals missed or delayed
49	○	○	○	Fatigue in afternoons
50	○	○	○	Overeating sweets upsets
	1	2	3	
51	○	○	○	Awaken after few hours sleep - hard to get back to sleep
52	○	○	○	Crave candy or coffee in afternoons
53	○	○	○	Moods of “blues” or melancholy
54	○	○	○	Craving for sweets or snacks
				GROUP 4
55	○	○	○	Hands and feet go to sleep easily, numbness
56	○	○	○	Sigh frequently, "air hunger"
57	○	○	○	Aware of "breathing heavily"
58	○	○	○	High altitude discomfort
59	○	○	○	Opens windows in closed rooms
60	○	○	○	Immune system challenges
61	○	○	○	Afternoon "yawner"
62	○	○	○	Get "drowsy" often
63	○	○	○	Swollen ankles, worse at night
64	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
65	○	○	○	Difficulty catching breath, especially during exercise
66	○	○	○	Tightness or pressure in chest, worse on exertion
67	○	○	○	Skin discolors easily after impact
68	○	○	○	Tendency to anemia
69	○	○	○	Noises in head, or "ringing in ears"
70	○	○	○	Fatigue upon exertion
				GROUP 5
71	○	○	○	Dizziness
72	○	○	○	Dry skin
73	○	○	○	Burning feet
74	○	○	○	Blurred vision
75	○	○	○	Itching skin and feet
76	○	○	○	Hair loss
77	○	○	○	Occasional skin rashes
78	○	○	○	Bitter, metallic taste in mouth in mornings
79	○	○	○	Occasional constipation
80	○	○	○	Worrier, feels insecure
81	○	○	○	Nausea occasionally after eating
82	○	○	○	Greasy foods upset
83	○	○	○	Stools light colored
84	○	○	○	Skin peels on foot soles
85	○	○	○	Discomfort between shoulder blades
86	○	○	○	Occasional laxative use
87	○	○	○	Stools alternate from soft to watery
88	○	○	○	Sneezing attacks
89	○	○	○	Dreaming, nightmare type bad dreams
90	○	○	○	Bad breath (halitosis)
91	○	○	○	Milk products cause upset
92	○	○	○	Sensitive to hot weather
93	○	○	○	Burning or itching anus
94	○	○	○	Crave sweets
				GROUP 6
95	○	○	○	Loss of taste for meat
96	○	○	○	Lower bowel gas several hours after eating
97	○	○	○	Burning stomach sensations, eating relieves
98	○	○	○	Coated tongue
99	○	○	○	Pass large amounts of foul-smelling gas
100	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
101	○	○	○	Watery or loose stool
102	○	○	○	Gas shortly after eating
103	○	○	○	Stomach "bloating"

	1	2	3	**GROUP 7A**
104	○	○	○	Difficulty sleeping
105	○	○	○	On edge
106	○	○	○	Can't gain weight
107	○	○	○	Intolerance to heat
108	○	○	○	Highly emotional
109	○	○	○	Flush easily
110	○	○	○	Night sweats
111	○	○	○	Thin, moist skin
112	○	○	○	Inward trembling
113	○	○	○	Heart races
114	○	○	○	Increased appetite without weight gain
115	○	○	○	Pulse fast at rest
116	○	○	○	Eyelids and face twitch
117	○	○	○	Irritable and restless
118	○	○	○	Can't work under pressure
				GROUP 7B
119	○	○	○	Increase in weight
120	○	○	○	Decrease in appetite
121	○	○	○	Fatigue easily
122	○	○	○	Ringing in ears
123	○	○	○	Sleepy during day
124	○	○	○	Sensitive to cold
125	○	○	○	Dry or scaly skin
126	○	○	○	Temporary constipation
127	○	○	○	Mental sluggishness
128	○	○	○	Hair coarse, falls out
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
				GROUP 7C
134	○	○	○	Failing memory with age
135	○	○	○	Increased sex drive
136	○	○	○	Episodes of tension in head
137	○	○	○	Decreased sugar tolerance
				GROUP 7D
138	○	○	○	Abnormal thirst
139	○	○	○	Bloating of abdomen
140	○	○	○	Weight gain around hips or waist
141	○	○	○	Sex drive reduced or lacking
142	○	○	○	Tendency for stomach issues
143	○	○	○	Increased sugar tolerance
144	○	○	○	Menstrual disorders
				GROUP 7E
145	○	○	○	Dizziness
146	○	○	○	Headaches
147	○	○	○	Hot flashes
148	○	○	○	Hair growth on face or body (female)
149	○	○	○	Sugar in urine (not diabetes)
150	○	○	○	Masculine tendencies (female)
				GROUP 7F
151	○	○	○	Weakness, dizziness
152	○	○	○	Tired throughout day
153	○	○	○	Nails weak, ridged
154	○	○	○	Sensitive skin
155	○	○	○	Stiff joints
156	○	○	○	Perspiration increase
157	○	○	○	Bowel discomfort
158	○	○	○	Poor circulation
159	○	○	○	Swollen ankles
160	○	○	○	Crave salt
161	○	○	○	Areas of skin darkening
162	○	○	○	Upper respiratory sensitivity
163	○	○	○	Tiredness
164	○	○	○	Breathing challenges

	1	2	3	**GROUP 8**
165	○	○	○	Muscle weakness
166	○	○	○	Lack of Stamina
167	○	○	○	Drowsiness after eating
168	○	○	○	Muscular soreness
169	○	○	○	Heart races
170	○	○	○	Hyper-irritable
171	○	○	○	Feeling of a band around your head
172	○	○	○	Melancholia (feeling of sadness)
173	○	○	○	Swelling of ankles
174	○	○	○	Change in urinary function
175	○	○	○	Tendency to consume sweets or carbohydrates
176	○	○	○	Muscle spasms
177	○	○	○	Blurred vision
178	○	○	○	Involuntary muscle action
179	○	○	○	Numbness
180	○	○	○	Night sweats
181	○	○	○	Rapid digestion
182	○	○	○	Sensitivity to noise
183	○	○	○	Redness of palms of hands and bottom of feet
184	○	○	○	Visible veins on chest and abdomen
185	○	○	○	Hemorrhoids
186	○	○	○	Apprehension (feeling that something bad will happen)
187	○	○	○	Nervousness causing loss of appetite
188	○	○	○	Nervousness with indigestion
189	○	○	○	Gastritis
190	○	○	○	Forgetfulness
191	○	○	○	Thinning hair
				FEMALE ONLY
192	○	○	○	Very easily fatigued
193	○	○	○	Premenstrual tension
194	○	○	○	Menses more painful than usual
195	○	○	○	Depressed feelings before menstruation
196	○	○	○	Painful breasts during menses
197	○	○	○	Menstruate too frequently
198			○	Hysterectomy / ovaries removed
199	○	○	○	Menopausal hot flashes
200	○	○	○	Menses scanty or missed
201	○	○	○	Acne, worse at menses
				MALE ONLY
202	○	○	○	Less involved in exercise/social activities
203	○	○	○	Difficult to postpone urination
204	○	○	○	Weak urinary stream
205	○	○	○	Feeling of “blues” or melancholy
206	○	○	○	Feeling of incomplete bowel evacuation
207	○	○	○	Lack of energy
208	○	○	○	Muscles in arms and legs seem softer/smaller
209	○	○	○	Tire too easily
210	○	○	○	Avoids activity
211	○	○	○	Leg nervousness at night
212	○	○	○	Diminished sex drive

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

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

History of Prescription Medication, OTC (Over the Counter), Supplements and other products

Name_____ Date _____

Please list any prescription medications you are currently taking or have taken in the last year.
Use other side if more room is needed. **Please print clearly**.

Medication/Dosage	Prescribed for what diagnosis/condition

Please list any (OTC) over-the-counter medications you are currently taking or have taken in the last year.

Product	Symptoms	Quantity & Frequency

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the past year.

Product	Symptoms	Quantity & Frequency

Check the items you use and indicate the amount and frequency. (Example: 1 liter coke/day)

☐ Coffee _____	☐ Power Drinks _____	☐ Ice Cream _____
☐ Soft drinks _____	☐ Laxatives_____	☐ Alcohol _____
☐ Diet Soft Drinks _____	☐ Artificial Sweetener _____	☐ Cigarettes _____
☐ Tea sweet/unsweet_____	☐ Antacids _____	☐ Other Tobacco _____
☐ Juice _____	☐ Candy _____	☐ Breakfast Bars_____

How many desserts do you have in an average week? _____