

**PATIENT INFORMATION**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex □ M □ F □Other Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_ Place of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Height\_\_\_\_\_\_Weight\_\_\_\_\_\_\_

Telephone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Single □ Married □ Divorced □ Widowed

Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Name of Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Birth Date \_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Relationship to Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship To Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT**

Complaint\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset: □ Sudden □ Gradual Date of onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a physician? \_\_\_\_\_\_\_\_\_\_\_\_ If yes, diagnosis was?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Health Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other therapies have you tried to manage this complaint?

□ Physical Therapy □ Chiropractic □ Medications □ Other (Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Rate the intensity of the PHYSICAL DISCOMFORT associated with the complaint:

(None) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Rate the intensity of the EMOTIONAL DISCOMFORT associated with the complaint:

(None) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Are the symptoms relieved by anything (if yes, please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are the symptoms worsened by anything (if yes, please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT**

On the diagram please mark the areas that you feel discomfort and label them:

A = Ache

B = Burning

P = Pins and Needles

S = Stabbing

N = Numbness

O = Other

List any medical problems and/ or diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgeries, accidents, hospitalizations, or problems

|  |  |  |
| --- | --- | --- |
| Year | Reason | Any Issues After? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

List all prescribed drugs and over the counter drugs (i.e. inhaler and vitamins)

|  |  |  |
| --- | --- | --- |
| Name of Drug and Dose | What For? | Taken How Long? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Allergies to Medications

|  |  |
| --- | --- |
| Name of Drug | Reaction You Had |
|  |  |
|  |  |
|  |  |

**HEALTH HABITS**

**Diet** Number of meals you eat in an average day? \_\_\_\_\_\_\_\_ times/ day

Water intake: □ High □ Medium □ Low

Do you prefer beverages: □ Cold □ Room Temp □ Warm/Hot

Diet limitations: □ Vegetarian □ Vegan □ Kosher □ Other\_\_\_\_\_\_\_\_\_\_

Sugar intake: □ High □ Medium □ Low □ No refined

**Caffeine** □ None □ Coffee □ Tea □ Soda Pop □ Sugar □ Cream

How many cups/ cans per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cups/ cans per day

**Alcohol** Do you drink alcohol? □ Yes □ No

If yes, how many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ drinks per week

Does drinking have an impact on your complaints? □ Yes □ No

If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco** Do you use tobacco? □ Yes □ No

□ Cigarettes \_\_\_\_pks/ day □ Chew \_\_\_\_/day □ Pipe\_\_\_\_/day □ Cigars\_\_\_\_\_/day

**Drugs** Do you currently use recreational drugs? □ Yes □ No

Does the use of drugs have an impact on your complaints? □ Yes □ No

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise** □ Yes □ No If yes, how often \_\_\_\_\_\_\_\_\_\_ what type of exercise \_\_\_\_\_\_\_\_\_\_\_ **Sleep** □ Difficulty falling asleep □ Frequent waking □ Difficulty waking

 □ Vivid dreams □ Nightmares

Please note all major illnesses in your immediate family, such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, and orthopedic disorders.

**FAMILY HEALTH HISTORY**

|  |  |  |
| --- | --- | --- |
| Relationship | Age | Major Illness |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**FEMALE GYNECOLOGICAL HISTORY**

Age of first menses \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of flow \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of cycle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood clots □ Yes □ No Color of menstrual blood \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Texture of menstrual blood □ Thick □ Thin □ Watery □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain □ Yes □ No If yes, please describe (when do they occur & why type of pain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get PMS? □ Yes □ No If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your periods irregular? □ Yes □ No If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current method of contraception \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past methods of contraception \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How is your sex drive □ High □ Low □ Normal How many times per week do you have sex \_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant? □ Yes □ No Number of pregnancies \_\_\_\_\_\_ Number of live births \_\_\_\_\_\_\_\_ Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_ Number of Abortions \_\_\_\_\_\_\_\_\_\_\_ Any premature births \_\_\_\_\_\_\_\_\_\_\_\_ Breast (lumps, cysts, tenderness, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Urinary tract infections □ Yes □ No How frequent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaginal discharge □ Thick □ Thin □ Abundant □ Normal □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pain/ itching of the genitalia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Normal □ Abnormal

Uterine fibroids \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Endometriosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Menopause (date of onset) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any bleeding since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently on Hormone Replacement Therapy (HRT) □ Yes □ No If yes, what dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long have you been on HRT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any side effects \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other, including STD history (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MALE HISTORY**

Do you experience □ Swollen Testes □ Testicular Pain □ Impotence □ Premature Ejaculation □ Feeling of coldness or numbness in the external genitalia □ Other, including STD history (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EASTERN SYMPTOMS**

Please check all the symptoms you have experienced within the last six months. If they do not apply, leave them blank. If you experience them frequently, check them twice. Some symptoms may be listed more than once, check them each time they occur.

**Section 1: Bi**

My condition feels better...

□ with cold

□ with heat

□ with rest

□ with exercise

□ without pressure

□ with pressure

□ in the morning

□ through the day

**Section 2: Qi**

□ Easily fatigued

□ Shortness of breath

□ Spontaneous sweating

□ Dizziness (Lightheaded)

□ Hard to project voice

□ Intermittent dull pain

□ Bloating/ Fullness

□ Sighing

□ Stuck feeling in throat

□ Repeated throat clearing

□ Pre-menstrual irritability

□ Cough

□ Asthma

□ Nausea

□ Vomiting

□ Belching

□ Hiccups

□ Hemorrhoids

□ Organ Prolapse (Sinking)

□ Chronic diarrhea

□ Bearing down sensation

**Section 3: Xue**

□ Pale face & nails

□ Blurry vision

□ Palpations

□ Numbness

□ Scanty menses

□ Short menstrual cycles

□ Dizziness (lightheaded)

□ Localized sharp pain

□ Lump, mass, or tumor

□ Painful menses

□ Irregular menses

□ Large red spots under skin

□ Feverish

□ Irritable

□ Bleeding

□ Red, painful skin eruptions

□ Heavy menses

**Section 4: Yang**

□ Feverish

□ Sweat easily

□ Thirst

□ Constipation

□ Red face

□ Sore throat or mouth

□ Dark, scanty urine

□ Irritable

□ Preference for cold drinks

□ Always kick off blankets

□ Prefer cold environment

□ Cold body

□ Cold limbs

□ Low sex drive

□ Chronically tired

□ Desire to sleep a lot

□ Retaining water

□ Always sleep with a blanket

□ Prefer warm environment

**Section 5: Yin**

□ Feverish in the afternoon

□ Night sweats

□ Dry mouth

□ Dry throat

□ Feverish palms & soles

□ Irritable

□ Insomnia

□ Flushed cheeks

**Section 6: Jing**

□ Premature graying

□ Hair loss

□ Tooth loss

□ Impotence

□ No sex drive

□ Memory loss

□ Infertility

**Section 7: JinYe**

□ Hoarse voice

□ Dry mouth

□ Dry skin

□ Dull, dry hair

□ Thirst

□ Dry stools

□ Scanty urine

□ Dry eyes and nose

**Section 8: Feng**

□ Sneezing

□ Clear runny nose

□ Aversion to drafts

□ Head & body aches

□ Nasal congestion

□ Chills & Fever

□ Spasms

□ Tremors

□ Dizziness, Vertigo

□ Stroke

□ Bells palsy

□ Stiffness

□ Numbness

□ Convulsions

□ Seizures

□ Paralysis

**Section 9: Shi**

□ Heavy feeling

□ Bloating & Swelling

□ Nausea

□ No thirst

□ Milky discharge

□ Loose stools

□ Weight gain

**Section 10: Tan**

□ Fullness in chest

□ Coughing up mucus

□ Frequently clearing throat

□ Decreased appetite

□ Wheezing

□ Dizziness

**Section 11: Fei**

□ Coughing

□ Asthma

□ Shortness of breath

□ Chest fullness

□ Chest pain

□ Wake up between 3-5 am

□ Sadness & grief

**Section 12: Xin**

□ Palpitations

□ Anxiety

□ Insomnia

□ Vivid dreaming

□ Chest pain

□ Left arm pain

□ Tongue sores or ulcers

□ Hysteria

□ Forgetfulness

**Section 13: Gan**

□ Pain in ribs

□ Pain in sides of trunk

□ Frequent anger

□ Frequent depression

□ Migraine headache

□ Vertigo

□ Ringing in ears

□ Red or painful eyes

□ Poor vision

□ Poor nail growth

**Section 14: Pi**

□ Low appetite

□ Diarrhea

□ Abdominal bloating

□ Nausea

□ Bleed easily

□ Bruise easily

□ Organ prolapse

□ Frequent worrying

**Section 15: Shen**

□ Painful low back

□ Weak low back

□ Painful knees

□ Weak knees

□ Poor vision

□ Poor hearing

□ Incontinence

□ Frequent urination

□ Nocturnal emission

□ Sexual dysfunction

□ Hair loss

□ Bone weakening

□ Infertility

□ Poor memory

□ Frequent fearful

**Section 16: Da Chang**

□ Constipation

□ Burning Anus, Rectum

□ Hemorrhoids

**Section 17: Xiao Chang**

□ Abdominal pain

□ Burning urination

□ Bearing down sensation in groin

**Section 18: Dan**

□ Right side trunk pain

□ Jaundiced skin

□ Bitter taste in mouth

□ Alternating chills & fever

□ Nausea

□ Vomiting bitter fluids

□ Easily frightened

□ Indecisive

□ Insomnia

**Section 19: Wei**

□ Stomach ulcer

□ Stomach pain

□ Acid regurgitation

□ Nausea

□ Vomiting

□ Swollen, painful gums

□ Bad breath

□ Always hungry

**Section 20: Pang Guang**

□ Painful, burning urination

□ Bladder stones

□ Kidney stones

□ Cloudy urine

□ Bloody urine

**WESTERN SYMPTOMS**

**Skin**

□ Rashes

□ Eczema

□ Acne

□ Purpura

□ Hair Loss

□ Change in Hair/ Skin Texture

□ Dryness

□ Itching

□ Excess Sweating

□ Dandruff

□ Night Sweats

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head**

□ Headache

□ Concussions

□ Migraines

□ Dizziness

□ Memory Loss

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes**

□ Blurred Vision

□ Floaters

□ Pain

□ Night Blindness

□ Redness

□ Dryness

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears, Nose, & Throat**

□ Poor Hearing

□ Ringing

□ Sinus Problems

□ Nosebleeds

□ Frequent Ear Infection

□ Frequent Cold

□ Drainage

□ Sore Throat

□ Difficulty Swallowing

□ Enlarged Thyroid

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mouth**

□ Gum Problems

□ Teeth Problems

□ Tongue/ Lip Sores

□ Jaw Clicking/ Pain/ TMJ

□ Unusual Taste \_\_\_\_\_\_\_\_\_\_\_

**Respiration**

□ Asthma

□ Bronchitis

□ Chest Pain

□ Cough

□ Coughing Blood

□ Emphysema

□ Difficulty Breathing

□ Phlegm

□ Wheezing

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heart & Thorax**

□ Palpitation

□ High Blood Pressure

□ Low Blood Pressure

□ Tightness in Chest

□ Prior Heart Attack

□ Heart Disease

□ **Pacemaker**

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circulation**

□ Bruise Easily

□ Anemia

□ Cold Hands and Feet

□ Fainting

□ Varicose Vein

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal**

□ Poor Appetite

□ Bad Breath

□ Excessive Hunger

□ Excessive Thirst

□ Belching

□ Heartburn

□ Gas

□ Nausea

□ Vomiting

□ Abdominal Pain/ Cramps/ Stomach Pain

□ Constipation

□ Loose Stools or Diarrhea

□ Black Stools

□ Hemorrhoids

□ Rectal Pain

□ Colitis or IBS

□ Gallbladder Trouble

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urogenital**

□ Frequent Urination

□ Difficulty Urinating

□ Burning Urination

□ Frequent UTIs

□ Dribbling of Urine

□ Waking to Urinate (\_\_\_times/night)

□ Retention of Urine/ Scanty Urination

□ Bedwetting

□ Pause of Flow in Urination

□ Itching of Genitals

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Energy Level**

□ Low Energy

□ Excessive Energy

□ Fluctuates a Lot

□ Energy Drop in the afternoon

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep**

□ Insomnia

□ Drowsiness

□ Night Sweats

□ Difficulty Falling Asleep

□ Difficulty Staying Asleep

□ Excessive Dreaming

□ Not Enough Sleep

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological**

□ Stiff Neck

□ Lower Back Soreness/ Weakness

□ Shoulder Trouble

□ Spinal Curvature

□ Pain Between Shoulders

□ Knee Trouble/ Pain

□ Swollen Joints

□ Painful Joints

□ Hip Pain

□ Arthritis

□ Hand/ Wrist Pain

□ Sprain

□ Hernia

□ Numbness or Tingling

□ Sciatica

□ Paralysis

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotional Issues**

□ Depression

□ Mood Swings

□ Mania/ Bipolar

□ Stressed

□ Anxiety

□ Bad Temper

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_