

Name _____ Date _____

Please check the symptoms or conditions you experience frequently.

- | Sp/St | Ht/P | Lu/LI | Ki/UB | Liv/GB |
|---|--|---|---|---|
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> insomnia | <input type="checkbox"/> cough | <input type="checkbox"/> low back pain | <input type="checkbox"/> eye problems |
| <input type="checkbox"/> loose stool/diarrhea | <input type="checkbox"/> palpitations | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> knee problems | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> digestive problems | <input type="checkbox"/> cold hands/feet | <input type="checkbox"/> decreased sense of smell | <input type="checkbox"/> hearing impairment | <input type="checkbox"/> gall stones |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> nightmares | <input type="checkbox"/> nasal problems | <input type="checkbox"/> ear ringing | <input type="checkbox"/> light-colored stool |
| <input type="checkbox"/> belching, burping | <input type="checkbox"/> mentally restless | <input type="checkbox"/> skin problems | <input type="checkbox"/> kidney stones | <input type="checkbox"/> soft/brittle nails |
| <input type="checkbox"/> heartburn/reflux | <input type="checkbox"/> laughing w/no cause | <input type="checkbox"/> claustrophobia | <input type="checkbox"/> decreased libido | <input type="checkbox"/> easily angered |
| <input type="checkbox"/> stomach bloating | <input type="checkbox"/> chest pains | <input type="checkbox"/> colitis/diverticulitis | <input type="checkbox"/> hair loss | <input type="checkbox"/> difficult relations |
| <input type="checkbox"/> obsession in work | <input type="checkbox"/> poor memory | <input type="checkbox"/> constipation | <input type="checkbox"/> urinary problems | <input type="checkbox"/> difficultly making decisions |
| <input type="checkbox"/> blood in stool | <input type="checkbox"/> sadness | <input type="checkbox"/> allergies | <input type="checkbox"/> dental problems | |
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> depression | <input type="checkbox"/> asthma | <input type="checkbox"/> fatigue | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> anxiety | <input type="checkbox"/> get sick easily | <input type="checkbox"/> edema | <input type="checkbox"/> headaches |
| <input type="checkbox"/> easily bruised | | | | |
| <input type="checkbox"/> usually feel warm | | | | |
| <input type="checkbox"/> usually feel chilled | | | | |

Please indicate if the following pertain to you.

- | | | |
|--|--|---|
| Kidney Yin Deficiency | Kidney Yang Deficiency | Spleen: Qi, Blood, and/or Yang Deficiency |
| <input type="checkbox"/> lower back weakness, soreness or pain | <input type="checkbox"/> sore or weak back | <input type="checkbox"/> often fatigued |
| <input type="checkbox"/> ringing in the ears | <input type="checkbox"/> cold feet especially at night | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> prematurely graying hair | <input type="checkbox"/> usually colder than others | <input type="checkbox"/> low energy after a meal |
| <input type="checkbox"/> dark circles under eyes | <input type="checkbox"/> low libido | <input type="checkbox"/> bloated after meal |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> often fearful | <input type="checkbox"/> crave sweets |
| <input type="checkbox"/> prone to hot flashes | <input type="checkbox"/> wake up in night to urinate | <input type="checkbox"/> loose stools, abdominal pain or digestive ills |
| <input type="checkbox"/> "afraid" frequently | <input type="checkbox"/> urinate frequently | <input type="checkbox"/> cold hands and/or feet |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> early morning loose urgent stools | <input type="checkbox"/> prone to feeling sluggish |
| <input type="checkbox"/> knee problems | <input type="checkbox"/> premenstrual low back pain | <input type="checkbox"/> prone to grogginess ggish |
| <input type="checkbox"/> vaginal dryness | <input type="checkbox"/> profuse vaginal discharge | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> midcycle cervical mucus scanty/missing | <input type="checkbox"/> menstrual cramps relieved by heat | <input type="checkbox"/> prone to worry |
| Blood Deficiency | | <input type="checkbox"/> diagnosed w/ low blood pressure |
| <input type="checkbox"/> dry, flaky skin | | <input type="checkbox"/> sweat easily w/o exertion |
| <input type="checkbox"/> prone to chapped lips | | <input type="checkbox"/> light-headed upon standing quickly |
| <input type="checkbox"/> fingernails/toenails brittle | | <input type="checkbox"/> often sick or allergies |
| <input type="checkbox"/> hair brittle or dry | | <input type="checkbox"/> hypothyroid or anemia |
| <input type="checkbox"/> poor night-time vision | | <input type="checkbox"/> hemorrhoids or polyps |
| <input type="checkbox"/> pale lips, inner lower eyelid or tongue | | <input type="checkbox"/> menstrual flow thin/watery/pink |
| <input type="checkbox"/> menstrual dizziness | | <input type="checkbox"/> uterine prolapse diagnosis |
| <input type="checkbox"/> hair loss on head | | <input type="checkbox"/> more tired at ovulation or menstruation |
| <input type="checkbox"/> menses scant or late | | <input type="checkbox"/> menstrual cramps w/ bearing down feeling |