

Patient Name _____ ID _____ Date _____

FILL IN THE DOT IF IT APPLIES TO A PROBLEM YOU HAVE OR HAD IN THE LAST SIX MONTHS OR LESS

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| <ul style="list-style-type: none"> <input type="checkbox"/> Acid food upset <input type="checkbox"/> Get chilled, often <input type="checkbox"/> "Lump" in throat <input type="checkbox"/> Dry mouth-eyes-nose <input type="checkbox"/> Pulse speeds after meals <input type="checkbox"/> Keyed up—fail to calm <input type="checkbox"/> Cuts heal slowly <input type="checkbox"/> Gag easily <input type="checkbox"/> Unable to relax; startles easily <input type="checkbox"/> Extremities cold, clammy <input type="checkbox"/> Strong light irritates <input type="checkbox"/> Urine amount reduced <input type="checkbox"/> Heart pounds after retiring <input type="checkbox"/> "Nervous" stomach <input type="checkbox"/> Appetite reduced <input type="checkbox"/> Cold sweats often <input type="checkbox"/> Fever easily raised <input type="checkbox"/> Neuralgia-like pains <input type="checkbox"/> Staring, blinks little <input type="checkbox"/> Sour stomach frequent <input type="checkbox"/> Joint stiffness after arising <input type="checkbox"/> Muscle-leg-toe cramps at night <input type="checkbox"/> "Butterfly" stomach, cramps <input type="checkbox"/> Eyes or nose watery <input type="checkbox"/> Eyes blink often <input type="checkbox"/> Eyelids swollen, puffy <input type="checkbox"/> Indigestion soon after meals <input type="checkbox"/> Always seem hungry; 'lightheaded' often <input type="checkbox"/> Digestion rapid <input type="checkbox"/> Vomiting frequent <input type="checkbox"/> Hoarseness frequent <input type="checkbox"/> Breathing irregular <input type="checkbox"/> Pulse slow; feels "irregular" <input type="checkbox"/> Gagging reflex slow <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Constipation, diarrhea alternating <input type="checkbox"/> "Slow starter" <input type="checkbox"/> Get "chilled" infrequently <input type="checkbox"/> Perspire easily <input type="checkbox"/> Circulation poor, sensitive to cold <input type="checkbox"/> Subject to colds, asthma, bronchitis <input type="checkbox"/> Eat when nervous <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Hungry between meals <input type="checkbox"/> Irritable before meals <input type="checkbox"/> Get "shaky" if hungry <input type="checkbox"/> Fatigue, eating relieves <input type="checkbox"/> "Lightheaded" if meals delayed <input type="checkbox"/> Heart palpitates if meals missed or delayed <input type="checkbox"/> Afternoon headaches <input type="checkbox"/> Overeating sweets upsets <input type="checkbox"/> Awaken after few hours sleep hard to get back to sleep <input type="checkbox"/> Crave candy or coffee in afternoons <input type="checkbox"/> Moods of depression "blues" or melancholy <input type="checkbox"/> Abnormal craving for sweets or snacks <input type="checkbox"/> Hands and feet go to sleep easily, numbness <input type="checkbox"/> Sigh frequently, "air hunger" <input type="checkbox"/> Aware of "breathing heavily" <input type="checkbox"/> High altitude discomfort <input type="checkbox"/> Opens windows in closed rooms <input type="checkbox"/> Susceptible to colds and fevers <input type="checkbox"/> Afternoon "yawner" <input type="checkbox"/> Get "drowsy" often <input type="checkbox"/> Swollen ankles worse at night <input type="checkbox"/> Muscle cramps, worse during exercise; "charley-horses" <input type="checkbox"/> Shortness of breath on exertion <input type="checkbox"/> Dull pain in chest or radiating into left arm, worse on exertion | <ul style="list-style-type: none"> <input type="checkbox"/> Bruise easily, "black/blue" spots <input type="checkbox"/> Tendency to anemia <input type="checkbox"/> "Nose bleeds" frequent <input type="checkbox"/> Noises in head or "ringing in ears" <input type="checkbox"/> Tension under the breast-bone, or feeling of "tightness", worse on exertion <input type="checkbox"/> Dry skin <input type="checkbox"/> Burning feet <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Itching skin and feet <input type="checkbox"/> Excess falling hair <input type="checkbox"/> Frequent skin rashes <input type="checkbox"/> Bitter, metallic taste in mouth in mornings <input type="checkbox"/> Bowel movements painful or difficult <input type="checkbox"/> Worrier, feels insecure <input type="checkbox"/> Feeling queasy; headache over eyes <input type="checkbox"/> Greasy foods upset <input type="checkbox"/> Stools light-colored <input type="checkbox"/> Skin peels on foot soles <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Use laxatives <input type="checkbox"/> Stools alternate from soft to watery <input type="checkbox"/> History of gallbladder attacks or gall stones <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Dreaming, nightmare-type bad dreams <input type="checkbox"/> Bad breath (halitosis) <input type="checkbox"/> Milk products cause distress <input type="checkbox"/> Sensitive to hot water <input type="checkbox"/> Burning or itching anus <input type="checkbox"/> Crave sweets <input type="checkbox"/> Loss of taste for meat <input type="checkbox"/> Lower bowel gas several hours after eating <input type="checkbox"/> Burning stomach sensations, eating relieves <input type="checkbox"/> Coated tongue <input type="checkbox"/> Pass large amounts of foul smelling gas <input type="checkbox"/> Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs. <input type="checkbox"/> Mucus colitis or "irritable bowel" <input type="checkbox"/> Gas shortly after eating <input type="checkbox"/> Stomach "bloating" after eating <input type="checkbox"/> Insomnia <input type="checkbox"/> Nervousness <input type="checkbox"/> Can't gain weight <input type="checkbox"/> Intolerance to heat <input type="checkbox"/> Highly emotional <input type="checkbox"/> Flush easily <input type="checkbox"/> Night sweats <input type="checkbox"/> Thin, moist skin <input type="checkbox"/> Inward trembling <input type="checkbox"/> Heart palpitates <input type="checkbox"/> Increased appetite without weight gain <input type="checkbox"/> Pulse fast at rest <input type="checkbox"/> Eyelids and face twitch <input type="checkbox"/> Irritable and restless <input type="checkbox"/> Can't work under pressure <input type="checkbox"/> Increase in weight <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Fatigue easily <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sleepy during day <input type="checkbox"/> Sensitive to cold <input type="checkbox"/> Dry or scaly skin <input type="checkbox"/> Constipation <input type="checkbox"/> Mental sluggishness <input type="checkbox"/> Hair coarse, falls out <input type="checkbox"/> Headaches upon arising, wear off during day <input type="checkbox"/> Slow pulse, below 65 <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Reduced initiative | <ul style="list-style-type: none"> <input type="checkbox"/> Failing memory <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Increased sex drive <input type="checkbox"/> Headaches, "splitting or rendering" type <input type="checkbox"/> Decreased sugar tolerance <input type="checkbox"/> Abnormal thirst <input type="checkbox"/> Bloating of abdomen <input type="checkbox"/> Weight gain around hips or waist <input type="checkbox"/> Sex drive reduced or lacking <input type="checkbox"/> Tendency to ulcers, colitis <input type="checkbox"/> Increased sugar tolerance <input type="checkbox"/> Women: menstrual disorders <input type="checkbox"/> Young girls: lack of menstrual function <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Hot flashes <input type="checkbox"/> Increased blood pressure <input type="checkbox"/> Hair growth on face or body (female) <input type="checkbox"/> Sugar in urine (not diabetes) <input type="checkbox"/> Masculine tendencies (female) <input type="checkbox"/> Weakness, dizziness <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Nails weak, ridged <input type="checkbox"/> Tendency to hives <input type="checkbox"/> Arthritic tendencies <input type="checkbox"/> Perspiration increase <input type="checkbox"/> Bowel disorders <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Crave salt <input type="checkbox"/> Brown spots or bronzing of skin <input type="checkbox"/> Allergies- tendency to asthma <input type="checkbox"/> Weakness after colds, influenza <input type="checkbox"/> Exhaustion-muscular and nervous <input type="checkbox"/> Respiratory disorders <input type="checkbox"/> Very easily fatigued <p><u>WOMEN ONLY</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Premenstrual tension <input type="checkbox"/> Painful menses <input type="checkbox"/> Depressed feelings before menstruation <input type="checkbox"/> Menstruation excessive and prolonged <input type="checkbox"/> Painful breasts <input type="checkbox"/> Menstruate too frequently <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Hysterectomy/ ovaries removed <input type="checkbox"/> Menopausal hot flashes <input type="checkbox"/> Menses scanty or missed <input type="checkbox"/> Acne, worse at menses <input type="checkbox"/> Depression-long standing <p><u>MEN ONLY</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Urination difficult or dribbling <input type="checkbox"/> Night urination frequent <input type="checkbox"/> Depression <input type="checkbox"/> Pain on inside of legs or heels <input type="checkbox"/> Feeling of incomplete bowel evacuation <input type="checkbox"/> Lack of energy <input type="checkbox"/> Migrating aches and pains <input type="checkbox"/> Tire too easily <input type="checkbox"/> Avoids activity <input type="checkbox"/> Leg nervousness at night <input type="checkbox"/> Diminished sex drive |
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