



## Patient Questionnaire

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Please check all the symptoms you have had within recent weeks and/or are presently experiencing.

### Sect. 1: Qi

Deficiency	Stagnation	Rebellious	Prolapse
<input type="checkbox"/> Fatigue easily <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Easily sweat <input type="checkbox"/> Dizziness <input type="checkbox"/> Hard to project voice	<input type="checkbox"/> Intermittent dull pain <input type="checkbox"/> Bloating and/or fullness <input type="checkbox"/> Sighing <input type="checkbox"/> Sensation of object stuck <input type="checkbox"/> Emotional prior to period	<input type="checkbox"/> Coughing <input type="checkbox"/> Asthma <input type="checkbox"/> Vomiting <input type="checkbox"/> Belching, hiccups	<input type="checkbox"/> Organ prolapse <input type="checkbox"/> Dizziness <input type="checkbox"/> Tired all the time <input type="checkbox"/> shortness of breath <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Descending sensation

### Sect. 2: Xue

Deficiency	Stagnation	Heat	
<input type="checkbox"/> Dizziness <input type="checkbox"/> Pale face and nails <input type="checkbox"/> Blurry vision <input type="checkbox"/> Palpations <input type="checkbox"/> Numbness <input type="checkbox"/> Scanty menses	<input type="checkbox"/> Local sharp pain <input type="checkbox"/> Lumps, mass or tumors <input type="checkbox"/> Large red spot under skin <input type="checkbox"/> Painful menses or irregular period	<input type="checkbox"/> Feverish <input type="checkbox"/> Irritable <input type="checkbox"/> Bleeding <input type="checkbox"/> Red, painful skin eruptions <input type="checkbox"/> Heavy menses	

### Sect. 3: Yang

### Sect. 4: Yin

Excess Heat	Deficient Yang	Excess Cold	Deficient Yin
<input type="checkbox"/> Feverish <input type="checkbox"/> Sweat easily <input type="checkbox"/> Thirsty <input type="checkbox"/> Constipation <input type="checkbox"/> Face red <input type="checkbox"/> Soar throat/mouth <input type="checkbox"/> Dark scanty urine <input type="checkbox"/> Irritable	<input type="checkbox"/> Cold body and limbs <input type="checkbox"/> Low sex drive <input type="checkbox"/> Always tired <input type="checkbox"/> Sleep a lot <input type="checkbox"/> Water retention	<input type="checkbox"/> Always cold <input type="checkbox"/> Frequent clear urine <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal pain spasm <input type="checkbox"/> Symptoms relieved by hot and cold liquid <input type="checkbox"/> Clear discharge	<input type="checkbox"/> Feverish at night <input type="checkbox"/> Night sweats <input type="checkbox"/> Dry mouth and throat <input type="checkbox"/> Feverish palms and soles of feet <input type="checkbox"/> Irritable <input type="checkbox"/> Insomnia <input type="checkbox"/> Flushed cheeks

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### Sect. 5: Jing

### Sect. 6: BF

### Sect. 7: Wind

<input type="checkbox"/> Premature gray hair <input type="checkbox"/> Hair loss <input type="checkbox"/> Tooth loss <input type="checkbox"/> Impotence <input type="checkbox"/> No sex drive <input type="checkbox"/> Memory loss <input type="checkbox"/> Infertility	<input type="checkbox"/> Hoarse voice <input type="checkbox"/> Dry mouth and skin <input type="checkbox"/> Dull and dry hair <input type="checkbox"/> Thirsty <input type="checkbox"/> Dry stools <input type="checkbox"/> Scanty urination <input type="checkbox"/> Dry eyes and nose	<b>External</b> <input type="checkbox"/> Sneezy <input type="checkbox"/> Clear runny nose <input type="checkbox"/> Fear of draft <input type="checkbox"/> Body and headache <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Chills and fever	<b>Internal</b> <input type="checkbox"/> Spasm and tremors <input type="checkbox"/> Dizzy and vertigo <input type="checkbox"/> Stroke <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Convulsions <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis
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### Sect. 8: Damp

### Sect. 9: Phlegm

### Sect. 10: Lungs

### Sect. 11: Heart

<input type="checkbox"/> Heaviness <input type="checkbox"/> Bloating and swelling <input type="checkbox"/> Nausea <input type="checkbox"/> No thirst <input type="checkbox"/> Milky discharge <input type="checkbox"/> Loose stools <input type="checkbox"/> Weight gain	<input type="checkbox"/> Chest fullness <input type="checkbox"/> Cough up mucus <input type="checkbox"/> Have to clear throat often <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Wheezing <input type="checkbox"/> Dizziness	<input type="checkbox"/> Sneezy <input type="checkbox"/> Clear runny nose <input type="checkbox"/> Fear of draft <input type="checkbox"/> Body and headache <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Chills and fever	<input type="checkbox"/> Spasm and tremors <input type="checkbox"/> Dizzy and vertigo <input type="checkbox"/> Stroke <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Convulsions <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis
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### Sect. 12: Liver

### Sect. 13: Spleen

### Sect. 14: Kidney

### Sect. 15: Lrg Int.

<input type="checkbox"/> Rib, side, trunk pain <input type="checkbox"/> Anger/depression <input type="checkbox"/> Migraine headache <input type="checkbox"/> Vertigo <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Red eye/pain <input type="checkbox"/> Poor vision <input type="checkbox"/> Poor nail growth	<input type="checkbox"/> Appetite low/none <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloating stomach/abdomen <input type="checkbox"/> Nausea <input type="checkbox"/> Bleeding <input type="checkbox"/> Organ prolapse <input type="checkbox"/> Worry too much	<input type="checkbox"/> Pain + weak low back <input type="checkbox"/> Pain + weak knees <input type="checkbox"/> Poor vision <input type="checkbox"/> Deafness <input type="checkbox"/> Incontinence <input type="checkbox"/> Nocturnal emission <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Hair/bone loss <input type="checkbox"/> Infertility <input type="checkbox"/> Poor memory <input type="checkbox"/> Constantly fearful	<input type="checkbox"/> Constipation <input type="checkbox"/> Burning sensation in anus/rectum <input type="checkbox"/> Hemorrhoids
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<b>Sect. 16: Small Int.</b>	<b>Sect. 17: Gall Bladder</b>	<b>Sect. 18: Stomach</b>	<b>Sect. 19: Bladder</b>
<ul style="list-style-type: none"><li><input type="checkbox"/> Bearing down feeling in groin and scrotum</li><li><input type="checkbox"/> Abdominal pain</li><li><input type="checkbox"/> Burning urination</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Right trunk pain</li><li><input type="checkbox"/> Yellowing of skin</li><li><input type="checkbox"/> Bitter taste in mouth</li><li><input type="checkbox"/> Alternate chills and fever</li><li><input type="checkbox"/> Nausea</li><li><input type="checkbox"/> Vomit bitter fluids</li><li><input type="checkbox"/> Frightens easily</li><li><input type="checkbox"/> Indecisive</li><li><input type="checkbox"/> Insomnia</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Stomach ulcer</li><li><input type="checkbox"/> Stomach pain</li><li><input type="checkbox"/> Acid regurgitation</li><li><input type="checkbox"/> Nausea/vomiting</li><li><input type="checkbox"/> Swollen, painful gums</li><li><input type="checkbox"/> Bad breath</li><li><input type="checkbox"/> Always hungry</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Painful burning urine</li><li><input type="checkbox"/> Bladder/kidney stones</li><li><input type="checkbox"/> Bloody/cloudy urine</li></ul>