



**Women's Acupuncture Intake Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

email: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Sex:  M  F Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Single  Married/Partnership  Divorced  Widowed  Separated

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBILITY AGREEMENT WITH CONSENT TO TREATMENT AND STATEMENT OF FINANCIAL POLICY**

**By signing below you acknowledge, understand and agree to the following:**

1. I am responsible for payment for all services rendered - payment due in full at the time of service. Back To Health Center will provide a receipt for me to submit to my insurance company.
2. I understand that unless 24 hours advanced notice is given, I am financially responsible for cancelled or missed appointments.
3. I hereby consent to acupuncture and related holistic treatments and evaluations rendered to me (or my child if a minor) by Dr. Andrew R. Dyer DC. I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.
4. Acupuncture is a healing therapy involving the insertion of fine needles into specific points along meridians on the body. In addition to the use of needles, the scope of acupuncture includes the use of electrical, mechanical or magnetic devices to stimulate acupuncture points, moxibustion, acupressure, cupping and/or infra-red therapy.
5. Acupuncture side effects may include some pain following treatment in the insertion area, temporary aggravation of symptoms existing prior to treatment, minor bruising, slight bleeding, dizziness, infection or needle sickness (fainting).
6. **If you are pregnant, taking anti-coagulant drugs (Coumadin), have a bleeding disorder, diabetes, heart condition, circulatory problems, blood clots, blood borne disease such as HIV or Hepatitis, cancer/malignancies, bone disorders, metal implants or have a pacemaker you should make that information known to Dr. Andrew Dyer DC prior to treatment.**
7. Acupuncture treatment is a complement to and not a substitute for Western medical care. Certain conditions may best be addressed in partnership with other health care providers.
8. I understand that my acupuncture practitioner follows universally prescribed precautions to guard against the spread of infection by using only sterilized, prepackaged, disposable needles. These needles will only be used on me and are inserted according to clean procedures based on nationally prescribed standards.

I have read and understand/agree to the information on this consent form.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



**Acupuncture Patient Questionnaire**

Have you had acupuncture before?  Y  N

Do you currently see a medical doctor?  Y  N

Name of Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Doctor's Diagnosis: \_\_\_\_\_

How are you responding to your present course of treatment?  Better  Worse  Same

Date of last appt with regular Physician: \_\_\_\_\_

**Family Medical History:**

- Cancer       Diabetes       Heart Disease       Stroke       Depression
- Seizure       Hepatitis       Thyroid Disease       Alcoholism       High Blood Pressure
- Other \_\_\_\_\_

**Please indicate if any of the following apply to you:**

- Cancer                       Heart Condition                       HIV/AIDS                       Stroke/CVA
- Diabetes                       Hemophiliac                       Lung Condition                       Takes Anticoagulants
- Epilepsy                       Hepatitis                       Pacemaker                       Vegetarian/Vegan

Surgeries: \_\_\_\_\_

Significant Trauma: \_\_\_\_\_

Birth History: \_\_\_\_\_

Allergies: \_\_\_\_\_

Exercise (type, duration, frequency): \_\_\_\_\_

Are you pregnant or is there any chance that you are pregnant?  Y  N

Medications: (list any medications, vitamins or food supplements taken in past two months)

Name:

Dosage:


**WEIGHT:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_

Have you experienced any height or weight gains/losses over the past year?  Y  N

Explain: \_\_\_\_\_

**LIFESTYLE:**

What are your primary sources of stress?

- 1.
- 2.
- 3.

How much do you think they impact you life? \_\_\_\_\_

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments:
Spouse/Significant Other						
Family						
Diet						
Self						
Work						
Exercise						
Spirituality						

Occupation? \_\_\_\_\_ Do you like your work?  Y  N

How many hours do you work per week? \_\_\_\_\_ Number of play/relaxation hours? \_\_\_\_\_

What do you do in order to manage stress and take care of yourself? : \_\_\_\_\_

What do you believe is your greatest challenge? \_\_\_\_\_

What do you think you need to do in order for you vision of health to happen? \_\_\_\_\_

What type of care do you desire?

- Temporary relief of symptoms/pain control
- Elimination of root cause of problem, if possible
- Maintenance care/balance to stay in good health
- Other \_\_\_\_\_

How would you classify your condition:

- Minor
- Worsening
- Serious
- Severe/Life Altering

What other therapies have you tried for this condition: \_\_\_\_\_

**CURRENT MEDICAL STATUS:**

Date of last full physical? \_\_\_\_\_ If abnormal, explain: \_\_\_\_\_

Any personal history of skin cancer?  Y  N

If over age 50, have you had a colonoscopy?  Y  N Date of colonoscopy? \_\_\_\_\_

Any positive findings on colonoscopy?  Y  N If yes, explain: \_\_\_\_\_

Date of last eye exam? \_\_\_\_\_ If abnormal, explain: \_\_\_\_\_

Do you visit the dentist regularly?  Y  N How frequent? \_\_\_\_\_

Do you have dental problems, gum inflammation or gingivitis?  Y  N

Explain: \_\_\_\_\_

**DIET:**

Are you on a restrictive diet?  Y  N

Is your diet physician prescribed?  Y  N If yes, for what condition? \_\_\_\_\_

Do you consider your diet healthy?  Y  N

Please describe a typical day's diet...

Breakfast	Lunch	Dinner	Snacks (what hour)

Estimated oz of water per day: \_\_\_\_\_

Caffeine Intake:  None  Coffee  Tea  Cola/Energy Drinks  
 # of cups/cans per day \_\_\_\_\_

Do you consume alcohol?  Y  N  
 If yes, what type? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_

Do you use tobacco?  Y  N If yes, what kind? \_\_\_\_\_  
 How many per day? \_\_\_\_\_ Number of years used: \_\_\_\_\_

Do you use recreational drugs?  Y  N  
 Type of drug: \_\_\_\_\_ Frequency: \_\_\_\_\_

**INDICATE WITH NUMBERS AS FOLLOWS:** (Leave blank any symptoms which do not apply)

- 1 – any condition occasionally experienced
- 2 – conditions which occur often
- 3 – symptoms which are a major concern

**Water Element**

- \_\_\_ Asthmatic Cough
- \_\_\_ Cold Intolerance
- \_\_\_ Dark Under Eyes
- \_\_\_ Diabetes
- \_\_\_ Dizziness
- \_\_\_ Edema
- \_\_\_ Emotional Instability
- \_\_\_ Excess Fear
- \_\_\_ Frequent Urination
- \_\_\_ Hair Thinning/Loss
- \_\_\_ Hearing Loss
- \_\_\_ Kidney Stones
- \_\_\_ Loose Teeth/Loss
- \_\_\_ Low Back Pain
- \_\_\_ Neck Pain
- \_\_\_ Perspire Easily
- \_\_\_ Premature Aging
- \_\_\_ Rapid Weight Change
- \_\_\_ Reduced Sexual Energy
- \_\_\_ Sinus Congestion
- \_\_\_ Thyroid Problems
- \_\_\_ Weak Legs/Knees

**Wood Element**

- \_\_\_ Constipation
- \_\_\_ Convulsions
- \_\_\_ Dry Eyes
- \_\_\_ Eczema
- \_\_\_ Eye Infection
- \_\_\_ Fullness Below Ribs
- \_\_\_ Gallstones
- \_\_\_ Headaches
- \_\_\_ Hemorrhoids
- \_\_\_ Hepatitis
- \_\_\_ Herpes
- \_\_\_ Indecisive
- \_\_\_ Insomnia
- \_\_\_ Irritability
- \_\_\_ Migraines
- \_\_\_ Neck Tension
- \_\_\_ Nervousness
- \_\_\_ Poor Eyesight
- \_\_\_ Ringing In Ears
- \_\_\_ Shingles
- \_\_\_ Shoulder Tension
- \_\_\_ Spasms
- \_\_\_ Ulcer
- \_\_\_ Vomiting
- \_\_\_ Warts

**Fire Element**

- \_\_\_ Bitter Taste In Mouth
- \_\_\_ Cysts/Tumors
- \_\_\_ Dark Urine
- \_\_\_ Dry Scalp
- \_\_\_ Ear Infection
- \_\_\_ Excess Joy
- \_\_\_ Facial Redness
- \_\_\_ Gum Problems
- \_\_\_ Heart Palpitations
- \_\_\_ Heat Intolerance
- \_\_\_ Hot Palms/Soles
- \_\_\_ Itch/Burning Skin
- \_\_\_ Lymph Swelling
- \_\_\_ Night Sweats
- \_\_\_ Nose Bleeds
- \_\_\_ Skin Rash
- \_\_\_ Sore Throat
- \_\_\_ Thirst
- \_\_\_ Vivid Dreaming

**Other**

- \_\_\_ Arthritis
- \_\_\_ Bursitis/Tendonitis
- \_\_\_ Cold Hands/Feet
- \_\_\_ Fatigue
- \_\_\_ Nerve Pain
- \_\_\_ Sciatica

**Metal Element**

- \_\_\_ Allergies
- \_\_\_ Asthma
- \_\_\_ Bronchitis
- \_\_\_ Cough
- \_\_\_ Grief/Weeping
- \_\_\_ Nose Infection
- \_\_\_ Sinus Problems
- \_\_\_ Skin Problems
- \_\_\_ Weak Breath

**Earth Element**

- \_\_\_ Acid Reflux
- \_\_\_ Anemia
- \_\_\_ Big Appetite
- \_\_\_ Bloating
- \_\_\_ Diarrhea
- \_\_\_ Excess Worry
- \_\_\_ Flatulence
- \_\_\_ Food Allergy
- \_\_\_ Halitosis
- \_\_\_ Heartburn
- \_\_\_ Indigestion
- \_\_\_ Mouth Sores
- \_\_\_ Obsessive
- \_\_\_ Stomach Ache
- \_\_\_ Ulcer
- \_\_\_ Underweight
- \_\_\_ Weak Appetite

**Other Symptoms/Systems:**

Please indicate if you regularly experience any of the following:

**Head & Neck:**

- |  |                                   |                                     |
|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Fainting | <input type="checkbox"/> Migraine   |
| <input type="checkbox"/> Enlarged lymph glands | <input type="checkbox"/> Headache | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Other: _____          |                                   |                                     |

**Eyes & Ears:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Burning/itching eyes  | <input type="checkbox"/> Dry eyes          | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Blurred vision        | <input type="checkbox"/> Earache           | <input type="checkbox"/> Spots/floaters  |
| <input type="checkbox"/> Chronic ear infection | <input type="checkbox"/> Eye pain          | <input type="checkbox"/> Vertigo         |
| <input type="checkbox"/> Decreased hearing     | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Visual changes  |
| <input type="checkbox"/> Other: _____          |  |  |

**Respiratory/Nose:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Cough with phlegm    | <input type="checkbox"/> Nasal congestion    |
| <input type="checkbox"/> Chronic Cough           | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Nosebleeds          |
| <input type="checkbox"/> Chronic sinus infection | <input type="checkbox"/> Frequent Colds       | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Coughing up blood       | <input type="checkbox"/> Hay fever/allergies  | <input type="checkbox"/> Wheezing/Asthma     |
| <input type="checkbox"/> Other: _____            |   |  |

**Genital/Urinary:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bedwetting                | <input type="checkbox"/> Frequent urination        | <input type="checkbox"/> Nighttime urination       |
| <input type="checkbox"/> Blood in urine            | <input type="checkbox"/> Genital lesions/discharge | <input type="checkbox"/> Pain/itching of genitalia |
| <input type="checkbox"/> Decreased libido          | <input type="checkbox"/> Kidney Stone              | <input type="checkbox"/> Painful/burning urination |
| <input type="checkbox"/> Excessive/scant urination | <input type="checkbox"/> Increased libido          | <input type="checkbox"/> Urgent urination          |
| <input type="checkbox"/> Other: _____              |  |  |

**Cardiovascular:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chest pain/tightness | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Swelling feet/ankles |
| <input type="checkbox"/> Heart palpitations   | <input type="checkbox"/> Poor circulation     | <input type="checkbox"/> Varicose veins       |
| <input type="checkbox"/> Other: _____         |   |   |

**Mouth & Throat:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Dry mouth      | <input type="checkbox"/> Recurrent sore throat     |
| <input type="checkbox"/> Bleeding gums         | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Tongue/Mouth sores/ulcers |
| <input type="checkbox"/> Difficulty swallowing |   |  |

**Muscles & Joints:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Body aches/stiffness     | <input type="checkbox"/> Joint discoloration | <input type="checkbox"/> Joint swelling    |
| <input type="checkbox"/> Generalized weakness     | <input type="checkbox"/> Joint pain          | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Heaviness" of body/limbs |  |  |
| <input type="checkbox"/> Other: _____             |  |  |

**Skin:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Dry skin         | <input type="checkbox"/> Itchy skin        |
| <input type="checkbox"/> Brittle/weak nails     | <input type="checkbox"/> Eczema/psoriasis | <input type="checkbox"/> Night sweats      |
| <input type="checkbox"/> Bruise easily          | <input type="checkbox"/> Hives/Rashes     | <input type="checkbox"/> Spontaneous sweat |
| <input type="checkbox"/> Changes in moles/lumps |   |  |
| <input type="checkbox"/> Other: _____           |   |  |

**Gastrointestinal:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Intestinal pain/cramping |
| <input type="checkbox"/> Anal fissures         | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Loose/soft stool         |
| <input type="checkbox"/> Bad breath            | <input type="checkbox"/> Gas            | <input type="checkbox"/> Mucous in stool          |
| <input type="checkbox"/> Black stool           | <input type="checkbox"/> Hemorrhoids    | <input type="checkbox"/> Nausea                   |
| <input type="checkbox"/> Bloating              | <input type="checkbox"/> Hiccups        | <input type="checkbox"/> Vomiting                 |
| <input type="checkbox"/> Other: _____          |   |   |

**Appetite/Thirst:**

- Temp of drinks most commonly desired:  Very cold       Tepid       Very Hot
- Exceedingly hungry       No thirst
- Excessive thirst       Poor appetite
- Hunger w/no desire to eat       Thirst w/no desire to drink
- Other: \_\_\_\_\_

**Sleep:**

- Difficulty waking up       Trouble staying asleep
- Sound/restful       Vivid dreaming/nightmares
- Trouble falling asleep       Wake easily
- # hours sleep/night: \_\_\_\_\_       Other: \_\_\_\_\_

**Emotions:**

- Angry/Frustrated       Fearful       Manic
- Anxious       Forgetful/poor memory       Relaxed/calm
- Depressed/sad       Impatient       Stressed
- Other: \_\_\_\_\_

**General:**

- Always feel cold       Cold hands/feet       Fever& Chills
- Always feel hot       Fatigue       Recent unexplained weight changes
- Other: \_\_\_\_\_

**WOMEN ONLY: (please select yes or no)**

**KIDNEY YIN DEFICIENCY**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Do you have low back weakness/soreness/pain, or knee problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have ringing in your ears or dizziness?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your hair prematurely gray?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have vaginal dryness?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your mid-cycle fertile cervical mucus scanty or missing?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have dark circles around or under your eyes?            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have night sweats?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you prone to hot flashes?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you describe yourself as one who is often afraid?        | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your tongue lack coating? Does it appear shiny or peeled? | <input type="checkbox"/> | <input type="checkbox"/> |

**KIDNEY YANG DEFICIENCY**

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| Do you have low back pain premenstrually?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your low back sore or weak?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have cold feet; especially at night?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you typically colder than those around you?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your libido low?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you often fearful?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wake up at night/early morning because you have to urinate?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you urinate frequently, and is the urine diluted and/or profuse?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have early morning loose, urgent stools?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have excess vaginal discharge?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel cold cramps during periods that respond to a heating pad? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is you tongue pale, moist, and swollen?                               | <input type="checkbox"/> | <input type="checkbox"/> |

**SPLEEN QI DEFICIENCY**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Are you fatigued?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a poor appetite?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your energy level lower after a meal?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel bloated after eating?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you crave sweets?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have loose stools, abdominal pain, or digestive problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your hands and feet cold?                                    | <input type="checkbox"/> | <input type="checkbox"/> |

Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>
Are you feeling heaviness or grogginess in the head?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot with minimal exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel dizzy/light-headed, or have altered vision if you stand up too fast?	<input type="checkbox"/>	<input type="checkbox"/>
Is your menstruation thin, watery, profuse, or pinkish in color?	<input type="checkbox"/>	<input type="checkbox"/>
Are you more tired around ovulation and menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever spot a few days or more before your period comes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with uterine prolapse?	<input type="checkbox"/>	<input type="checkbox"/>
Are cramps accompanied by a bearing-down sensation in your uterus?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often sick, or do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look swollen with teeth marks on the sides?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pale, yellowish complexion?	<input type="checkbox"/>	<input type="checkbox"/>

**BLOOD DEFICIENCY**

	<b>Yes</b>	<b>No</b>
Are your menses scant and/or late?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry, flaky skin?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to getting chapped lips?	<input type="checkbox"/>	<input type="checkbox"/>
Are your fingernails or toenails brittle?	<input type="checkbox"/>	<input type="checkbox"/>
Are you losing the hair on your head (not patches, but all over)?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair brittle or dry?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diminished nighttime vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy or light-headed around your period?	<input type="checkbox"/>	<input type="checkbox"/>
Are your lips, the inner side of your lower eyelids, or tongue pale in color?	<input type="checkbox"/>	<input type="checkbox"/>

**BLOOD STASIS**

	<b>Yes</b>	<b>No</b>
Is your menstrual flow ever brown or black in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel mid-cycle pain around your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have painful, unmovable breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience periodic numbness in your hands and feet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose or spider veins?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have red hemangiomas (cherry-red spots) on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Does your complexion appear dark and "sooty"?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain clots?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with endometriosis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>
Is your lower abdomen tender to palpation (resisting touch)?	<input type="checkbox"/>	<input type="checkbox"/>
Can you feel any abdominal lumps in your lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have piercing or stabbing menstrual cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look dark?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots on your tongue?	<input type="checkbox"/>	<input type="checkbox"/>
Are the veins beneath your tongue twisty and tortuous?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>

**LIVER QI STAGNATION**

	<b>Yes</b>	<b>No</b>
Are you prone to emotional depression?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to anger and/or rage?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become irritable premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated and irritable around ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Does it feel as if your ovulation lasts longer than it should?	<input type="checkbox"/>	<input type="checkbox"/>
Are your breasts sensitive/sore at ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience nipple pain or discharge from your nipples?	<input type="checkbox"/>	<input type="checkbox"/>

Have you been diagnosed with elevated prolactin levels?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become bloated prior to menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
Are your pupils dilated and large?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep at night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience heartburn or wake up with a bitter taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your menses painful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your menstrual cramps in the external genital area?	<input type="checkbox"/>	<input type="checkbox"/>
Is the menstrual blood thick and dark, or purplish in color?	<input type="checkbox"/>	<input type="checkbox"/>

<b>HEART DEFICIENCY</b>	<b>Yes</b>	<b>No</b>
Do you wake early and have trouble getting back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart palpitations, especially when anxious?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>
Do you seem low in spirit or lacking in vitality?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you fidget?	<input type="checkbox"/>	<input type="checkbox"/>
Is the tip of your tongue red?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a crack in the center of your tongue that extends to the tip?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat excessively, especially on your chest?	<input type="checkbox"/>	<input type="checkbox"/>

<b>EXCESS HEAT</b>	<b>Yes</b>	<b>No</b>
Is your pulse rate rapid?	<input type="checkbox"/>	<input type="checkbox"/>
Are your mouth and throat usually dry?	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty for cold drinks most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel warmer than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up sweating or have hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you break out with red acne (especially pre-menstrual)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a short menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal irritation or rashes?	<input type="checkbox"/>	<input type="checkbox"/>

<b>DAMPNESS</b>	<b>Yes</b>	<b>No</b>
Do you feel tired and sluggish after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have fibrocystic breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cystic or pustular acne?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have urgent, bright, or foul-smelling stools?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain stringy tissue or mucus?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infections and vaginal itching?	<input type="checkbox"/>	<input type="checkbox"/>
Do your joints ache, especially with movement?	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a wet slimy tongue?	<input type="checkbox"/>	<input type="checkbox"/>

<b>DAMP HEAT</b>	<b>Yes</b>	<b>No</b>
Do you have foul-smelling, yellow, or greenish vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal or rectal itching during luteal or premenstrual phase?	<input type="checkbox"/>	<input type="checkbox"/>

<b>COLD UTERUS</b>	<b>Yes</b>	<b>No</b>
Do you fit the Kidney Yang deficiency category?	<input type="checkbox"/>	<input type="checkbox"/>
Do you fall into the Blood Stasis pattern?	<input type="checkbox"/>	<input type="checkbox"/>
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	<input type="checkbox"/>	<input type="checkbox"/>