

Patient Symptoms and Evaluations

Check the box when you experience the symptom

Please indicate symptoms that are current (c) or past (p)

When answering the following please rate with a number

“1” occasionally, mildly

“2” frequently, moderately severe

“3” disabling or persistent

Headache and Dizziness

Headaches that have :

- radiating pain
- dull pain
- sharp pain

Location

- forehead
- occipital (base of the skull)
- at the temples
- top of head

Dizziness yes no

how frequent?

Blood pressure _____ mmhg

Hair and Skin

- Hair falls out frequently
- premature graying
- dry hair
- oily hair

- skin rashes
- dry skin
- easily bruised
- acne
- other

Ears Nose Throat and Mouth

- history of earaches
- tinnitus/ ringing of the ears
- high pitched
- low pitched
- abnormal ear discharge
- vertigo/ difficulty keeping balance

- nosebleeds
- history of sore throats
- frequently blow your nose (even when you aren't sick)
- swollen glands

Eyes and Mouth

- eye pain / swelling
- blurry vision / visual spots
- red, itchy eyes

- do you clench your jaw?
- experience foul breath
- bleeding in the gums

Chest and Cough

- dry cough with phlegm
- shortness of breath / wheezing
- asthma
- frequent colds

- burning chest pain
 - rapid heart beat
 - distending/ chest fullness
 - chest tightness
 - palpitation / feel your heart beat abnormally
- Do you experience anxiety?

Digestion

- belching nausea
- indigestion esophageal reflux
- hiccup vomiting gas

Stomach pain

- burning distending (moves around)
- dull pain
- pain after eating

Appetite

- decreased
- increased

Bowel Movement:

frequency _____

Constipation:

- yes
- dry stool
- difficult to expectorate

Diarrhea

- yes
- watery stool
- foul odor stool
- abdominal pain following stool
- undigested food in the stool
- at dawn

Urination

Frequency(relative to intake)

- low (6 per day)
- high (8 per day)

colour:

- clear

dark

Painful urination

yes

no

Difficulty holding

yes

no

Incontinence (leaking)

yes

no

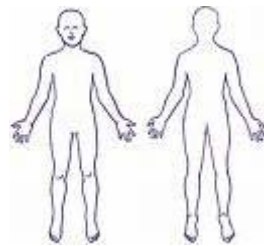
Enuresis(inability to control urine especially during the night)

yes

no

Muscles and Joints

please circle and indicate the area of pain and swelling



heavy sensation over body and limbs

low back pain

knee soreness

numbness or tingling

Body Temperature:

alternating fever and chills

dislike of heat

dislike of cold

night sweats

daytime sweats

Sexual Energy

increased

decreased

Female Section :

Menopause

yes

no

If yes, when was your last cycle? _____

Menstruation: When was you first day of your last cycle? _____

cycle:

regular

early

delayed

irregular

How many days of bleeding is your cycle? ____

- Quantity heavy
 light
- color bright/ fresh blood red
 light pink red dark/ black red
- property stringy clots
 thick with (quarter sized clots)
- cramps yes no
- Do you take medication or herbs for the pain? _____
- amenorrhea (absence of period) yes no
- When was your last cycle?
- spotting (in between periods) yes no
- Leukorrhea with white/yellow discharge yes no

Pregnancy

- Are you pregnant/ trying to get pregnant yes no
- How many children do you have? _____
- Normal delivery? yes no
- Miscarriages yes no

General Information

- Energy level low high
- Sleep difficulty falling asleep
 Wakes frequently through the night
- Weight loss gained
- Thirst usually seldom
- Is there a prominent emotion that you experience that may be a sign of imbalance?
 sadness anger/frustration
 depression other

Thank you for taking the time to fill out these forms, they will help me see a clear picture of your overall diagnosis for Traditional Chinese Medicine.

