

**Female:**

- |  |  |   |  |
|--|--|---|--|
| Age menses began _____                     | <input type="checkbox"/> Spotting            | <input type="checkbox"/> Pale red             | <input type="checkbox"/> Vaginal discharge disease |
| Days in cycle _____                        | <input type="checkbox"/> Days in cycle _____ | <input type="checkbox"/> Maroon               | <input type="checkbox"/> Sexually transmitted      |
| Days of flow _____                         | <input type="checkbox"/> Cramping during     | <input type="checkbox"/> Brown                | <input type="checkbox"/> Genital pain/sores        |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Light flow          | <input type="checkbox"/> Premenstrual tension | <input type="checkbox"/> Pain with intercourse     |
| <input type="checkbox"/> No periods        | <input type="checkbox"/> Moderate flow       | <input type="checkbox"/> Breast tenderness    | <input type="checkbox"/> Use birth control         |
| <input type="checkbox"/> Pregnant now      | <input type="checkbox"/> Heavy flow          | <input type="checkbox"/> Melancholy           | <input type="checkbox"/> Oral contraceptives       |
| Number of pregnancies _____                | <input type="checkbox"/> Small clots         | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Menopause                 |
|  | <input type="checkbox"/> Large clots         | <input type="checkbox"/> High sexual energy   |  |
|  |  | <input type="checkbox"/> Low sexual energy    |  |

**Male:**

- |   |   |   |  |
|---|---|---|--|
| Genital pain/sores  | <input type="checkbox"/> Lump in testicles    | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Low sexual energy |
| <input type="checkbox"/> Impotence <input type="checkbox"/> | <input type="checkbox"/> Discharge from penis | <input type="checkbox"/> High sexual energy | <input type="checkbox"/> Prostate problem  |

**Emotional/mental**

- |   |                                    |  |  |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Lots of stress | <input type="checkbox"/> Cry a lot | <input type="checkbox"/> Terrors         | <input type="checkbox"/> Unrestrained joy        |
| <input type="checkbox"/> Irritability   | <input type="checkbox"/> Isolative | <input type="checkbox"/> Happiness       | <input type="checkbox"/> Hard to express feeling |
| <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Worry     | <input type="checkbox"/> Thoughts cloudy | <input type="checkbox"/> Feel depressed          |
| <input type="checkbox"/> Anger          | <input type="checkbox"/> Fear      | <input type="checkbox"/> Poor memory     |  |
| <input type="checkbox"/> Sadness        | <input type="checkbox"/> Shyness   | <input type="checkbox"/> Hard to focus   |  |

**Pain:**

- |                                     |                                       |  |   |
|-------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Head       | <input type="checkbox"/> Ribs         | <input type="checkbox"/> Joints red        | <input type="checkbox"/> On surface           |
| <input type="checkbox"/> Face       | <input type="checkbox"/> Lower back   | <input type="checkbox"/> Joints painful    | <input type="checkbox"/> Deep in body         |
| <input type="checkbox"/> Neck       | <input type="checkbox"/> Hips         | <input type="checkbox"/> Pain moves around | <input type="checkbox"/> Better with pressure |
| <input type="checkbox"/> Shoulders  | <input type="checkbox"/> Knees        | <input type="checkbox"/> In one location   | <input type="checkbox"/> Worse with pressure  |
| <input type="checkbox"/> Arms       | <input type="checkbox"/> Legs         | <input type="checkbox"/> Dull/achy         | <input type="checkbox"/> Better with heat     |
| <input type="checkbox"/> Hands      | <input type="checkbox"/> Feet         | <input type="checkbox"/> Sharp/stabbing    | <input type="checkbox"/> Better with cold     |
| <input type="checkbox"/> Upper back | <input type="checkbox"/> Joints swell | <input type="checkbox"/> Hot/burning       | <input type="checkbox"/> Worse in morning     |

**Headache**

- |  |  |  |                                    |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Front of the head | <input type="checkbox"/> Top of the head | <input type="checkbox"/> Throbs              | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Back of the head  | <input type="checkbox"/> Forehead        | <input type="checkbox"/> Feels full/pressure | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Side of the head  | <input type="checkbox"/> Behind eyes     | <input type="checkbox"/> Dull/achy           | How Often? _____                   |

**Head and neck**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Eyes red           | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Tongue/lip sores | <input type="checkbox"/> Enlarged thyroid    |
| <input type="checkbox"/> Eyes itchy         | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Mouth sores      | <input type="checkbox"/> Ringing in ears     |
| <input type="checkbox"/> Dry eyes           | <input type="checkbox"/> Teeth problems  | <input type="checkbox"/> Gum problems     | <input type="checkbox"/> High pitch          |
| <input type="checkbox"/> Watery eyes        | <input type="checkbox"/> Grinding teeth  | <input type="checkbox"/> Sinus problems   | <input type="checkbox"/> Low pitch           |
| <input type="checkbox"/> Blurry vision      | <input type="checkbox"/> Tight jaw       | <input type="checkbox"/> Post nasal drip  | <input type="checkbox"/> Hearing loss        |
| <input type="checkbox"/> Corrective glasses | <input type="checkbox"/> Red face        | <input type="checkbox"/> Nose bleeds      | <input type="checkbox"/> Earaches            |
| <input type="checkbox"/> Floaters           | <input type="checkbox"/> Facial pain     | <input type="checkbox"/> Swollen glands   | <input type="checkbox"/> Concussions         |
| <input type="checkbox"/> Poor night vision  | <input type="checkbox"/> Facial numbness | <input type="checkbox"/> Lump in throat   | <input type="checkbox"/> Dry/scratchy throat |

**Respiratory:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Shortness of breath           | <input type="checkbox"/> Chest tight          | <input type="checkbox"/> White phlegm  | <input type="checkbox"/> Blood in phlegm |
| <input type="checkbox"/> Asthma/wheezing               | <input type="checkbox"/> Dry cough            | <input type="checkbox"/> Yellow phlegm | <input type="checkbox"/> Bronchitis      |
| <input type="checkbox"/> Sleep in more than one pillow | <input type="checkbox"/> Cough with cold      | <input type="checkbox"/> Thin phlegm   | <input type="checkbox"/> Pneumonia       |
|  | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Thick phlegm  | <input type="checkbox"/> Dizziness       |

**Habits:**

- |                                    |                                  |                                  |                                       |
|------------------------------------|----------------------------------|----------------------------------|---------------------------------------|
| Cups of coffee                     | Alcohol                          | Recreational drugs               | Cigarettes                            |
| <input type="checkbox"/> 1 - 2/day | <input type="checkbox"/> Daily   | <input type="checkbox"/> Daily   | <input type="checkbox"/> 1/2 pack/day |
| <input type="checkbox"/> 2 - 4/day | <input type="checkbox"/> Weekly  | <input type="checkbox"/> Weekly  | <input type="checkbox"/> 1 pack/day   |
| <input type="checkbox"/> >4/day    | <input type="checkbox"/> Monthly | <input type="checkbox"/> Monthly | <input type="checkbox"/> 2 packs/day  |