

### Symptoms & Indications

**DO YOU HAVE:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Frequent urination    | <input type="checkbox"/> Cough with phlegm     | <input type="checkbox"/> Painful joints          |
| <input type="checkbox"/> Painful urination     | <input type="checkbox"/> Hay fever             | <input type="checkbox"/> Pain in hip             |
| <input type="checkbox"/> Nighttime urination   | <input type="checkbox"/> Sinusitis             | <input type="checkbox"/> Pain in ankle           |
| <input type="checkbox"/> Dark-colored urine    | <input type="checkbox"/> Acne                  | <input type="checkbox"/> Pain in shoulder        |
| <input type="checkbox"/> Impaired hearing      | <input type="checkbox"/> Dry skin              | <input type="checkbox"/> Pain in elbow           |
| <input type="checkbox"/> Ringing in the ear    | <input type="checkbox"/> Itching               | <input type="checkbox"/> Pain in wrist           |
| <input type="checkbox"/> Hair loss or thinning | <input type="checkbox"/> Psoriasis             | <input type="checkbox"/> Pain in foot            |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Bruise easily         | <input type="checkbox"/> Sciatica                |
| <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Insomnia              | <input type="checkbox"/> Prostrate trouble (MEN) |
| <input type="checkbox"/> Bloody stool          | <input type="checkbox"/> Worry or anxiety      |  |
| <input type="checkbox"/> Indigestion           | <input type="checkbox"/> Depression            | <b>WOMEN</b>                                     |
| <input type="checkbox"/> Abdominal pain        | <input type="checkbox"/> Nervousness           | <input type="checkbox"/> Yeast or vaginitis      |
| <input type="checkbox"/> Lower bowel gas       | <input type="checkbox"/> Poor concentration    | <input type="checkbox"/> Uterine cysts/tumors    |
| <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Forgetfulness         | <input type="checkbox"/> Water retention         |
| <input type="checkbox"/> Abdominal bloating    | <input type="checkbox"/> Morning fatigue       | <input type="checkbox"/> Mood changes            |
| <input type="checkbox"/> Nausea                | <input type="checkbox"/> Afternoon fatigue     | <input type="checkbox"/> Painful breasts         |
| <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Low/no sex drive        |
| <input type="checkbox"/> Sores on the tongue   | <input type="checkbox"/> Migraines             | <input type="checkbox"/> Hot flashes             |
| <input type="checkbox"/> Hiccups               | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Missed periods          |
| <input type="checkbox"/> Bleeding gums         | <input type="checkbox"/> Blurred vision        | Date of most recent period:                      |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Dry eyes              | _____  |
| <input type="checkbox"/> Increased appetite    | <input type="checkbox"/> Brittle nails         | <b>WOMEN &amp; MEN, DO YOU:</b>                  |
| <input type="checkbox"/> Decreased appetite    | <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Exercise regularly      |
| <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Pain under the ribs   | <input type="checkbox"/> Get good sleep          |
| <input type="checkbox"/> Irregular heartbeat   | <input type="checkbox"/> Heat intolerance      | <input type="checkbox"/> Eat regular meals       |
| <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Cold intolerance      | <input type="checkbox"/> Drink enough water      |
| <input type="checkbox"/> Fainting              | <input type="checkbox"/> Muscle spasm          | <input type="checkbox"/> Have stressful job/life |
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Bursitis              | <input type="checkbox"/> Prefer hot drinks       |
| <input type="checkbox"/> Leg cramps            | <input type="checkbox"/> Stiff or painful neck | <input type="checkbox"/> Prefer cold drinks      |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Weak limbs            |  |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Loss of grip/strength | <b>DO YOU NEED:</b>                              |
| <input type="checkbox"/> Frequent colds        | <input type="checkbox"/> Hand or finger pain   | <input type="checkbox"/> Tibetan herbs           |
| <input type="checkbox"/> Ankle swelling        | <input type="checkbox"/> Poor circulation      | <input type="checkbox"/> Diet                    |
| <input type="checkbox"/> Easily chilled        | <input type="checkbox"/> Numb/tingling limbs   | <input type="checkbox"/> Special exercise        |
| <input type="checkbox"/> Excessive sweating    | <input type="checkbox"/> Pain in upper back    | <input type="checkbox"/> Contemplative or        |
| <input type="checkbox"/> Easily fatigued       | <input type="checkbox"/> Pain in mid back      | spiritual practice                               |
| <input type="checkbox"/> Dry cough             | <input type="checkbox"/> Pain in lower back    |  |

DO NOT MAIL – Please bring this form to your first appointment.