TRADITIONAL CHINESE HERBAL ASSESSMENT FORM

NAME:_____

Please circle all the relevant symptoms you are currently experiencing or have recently experienced and checkmark how often you are experiencing these symptoms.
Please don't brush your tongue for at least 3 days prior to your appointment.

SYSTEMIC:	**Never**	**Rarely**	**Sometimes**	**Often**
Do you tend to feel more hot ***or*** cold?				
Do you tend to feel more hot ***or*** cold in the trunk of the body?				
Do you get cold hands ***or*** feet easily?				
Do you like to sleep with a lot of covers ***or*** with few covers?				
Do you throw your covers off at night ***or*** do you need to add them?				
Do you sleep with socks in bed?				
Do you prefer a cold ***or*** a hot climate?				
Do you have an inability to tolerate temperature extremes?				
Do you dress in layers more so than others around you?				
Do you experience hot flashes, day sweats, ***or*** tend to feel hot, dislike heat ***or*** experience hot palms, soles ***or*** head during the day?				
Do you experience night sweats ***or*** hot flashes during the night?				
Do you tend to perspire very easily (excluding day or night sweats)?				
Do you tend not to perspire very easily?				
Do you have a tendency to perspire spontaneously?				
Do you experience fatigue in the morning with ***adequate*** sleep?				
Do you experience chronic fatigue ***or*** lethargy any time of the day?				
Do you experience more fatigue around 3 o'clock in the afternoon?				
Does exercise tend to aggravate ***or*** relieve fatigue?				

RESPIRATION:	**Never**	**Rarely**	**Sometimes**	**Often**
Do you get unusually of short of breath when physically active?				
Do you get short of breath without being physically active?				
Do you have difficulty inhaling requiring effort to expand the lungs in the last moment of your breath?				
Do you have asthma? If yes:				
Do you have exercised induced asthma?				
Do you have more ***or*** equal difficulty inhaling ***or*** exhaling?				
Do you wheeze on the inhale ***or*** exhale?				
Do you have more difficulty breathing when laying down?				
Do you have chest congestion with ***or*** without coughing up phlegm?				
Is the discharge clear, white, yellow, runny, ***or*** thick?				
Do you have a tendency to clear your throat ?				
Does it often feel like something is stuck in your throat?				
Do you have an unproductive cough?				

INTAKE:	**Never**	**Rarely**	**Sometimes**	**Often**
Do you tend to get thirsty ***or*** you are hardly ever thirsty?				
Are you often thirsty with a dry mouth ***or*** throat ***or*** have a tendency to clear your throat?				
In general, do you rather drink hot ***or*** cold drinks?				
Do you like to drink cold drinks in the winter?				
Do you shy away from cold drinks in b/c they make you cold?				
Do you tend to lack hunger ***or*** experience excessive hunger?				
Do you tend to experience excessive appetite, are always thirsty, desire cold drinks, ***or*** have burning stomach pain?				

OUTFLOW:	**Never**	**Rarely**	**Sometimes**	**Often**
Does your urine tend to be dark ***or*** light-colored (straw)?				
Do you sometimes have cloudy urine ***or*** blood in urine?				
Do you experience burning upon urination?				
Do you experience frequent urgent ***or*** painful urination with discomfort in the lower abdomen?				
On average how many times a day do you urinate?____times. How many times during the night do you get up to urinate?___times. Do you ever experience urinary ***or*** bowel incontinence?___no___yes. After sneezing only?__During the day or night?___ What is the color of your stool? Dark/Medium/Light brown__Yellow/green__Black__Tan gray__ How many stools do you tend to have a day?_____ Do you tend more towards having formed stool, constipation, loose stool ***or*** diarrhea? What is your predominant stool consistency?(circle which apply): Formed, pebbly, pasty, pencil-like, cow pie, loose pieces, runny				
Do you have loose stool with watery gurgling noises?				
Do you ever see undigested food in your stool?				
Do ever see pus ***or*** blood in your stool?				
Do you tend to have unusually foul smelling stools?				
Do you experience burning sensation in anus after passing stools?				
Before ***or*** after passing a bowel movement, do you experience: abdominal pains, cramps, ***or*** a prolonged urge to defecate?				
Do you ever see blood in your sputum, vomit, stool, urine, ***or*** nasal secretions?				
Do you have bleeding gums ***or*** loose teeth?				
Do you experience sinus congestion, discharge ***or*** sneezing? Is the discharge clear, white, yellow, runny, ***or*** thick?				
Do you have carbuncles, boils, acne, ***or*** other skin lesions?				
Do you bruise easily ***or*** have purple spots on skin?				
Do you ever have fluid-filled watery ***or*** oozing skin eruptions?				

WOMEN ONLY (If postmenopausal, give past history)	**Never**	**Rarely**	**Sometimes**	**Often**
Are you Pre__ or Post __Menopausal? Dates of Last Period_____				
Do you have vaginal dryness, too much vaginal discharge,				
or frequent yeast infections?				
Do your periods tend to come too early ***or*** to late?				
Do you experience excessive ***or*** scant ***or*** absent menstrual flow?				
Do you have prolonged menstrual bleeding (excess of 7 days)?				
During your menses, does the tend to be blood pale ***and*** thin?				
Is the color of the blood dark, bright, ***or*** scarlet red?				
Is the blood purplish ***or*** clotted?				
Is the blood brownish?(excluding towards the end)				
Do you have cramping before ***or*** during your period?				
Do you tend to have loose stool before ***or*** during your period?				
Do you experience *premenstrual* breast tenderness, mood swings				
headaches, lower back pain, fluid retention, ***or*** bloating?				

PAIN & DISCOMFORTS	**Never**	**Rarely**	**Sometimes**	**Often**
Please circle which apply: Do you experience acid reflux,				
heart burn, indigestion, painful bowel gas,				
painless bowel gas, hiccough, belching, ***or*** nausea?				
When do you experience these? After Breakfast, lunch, ***or*** dinner?				
Which foods seem to aggravate it?				
Do you experience full oppressive bloated feeling in the chest				
or abdomen? When?				
Do you experience any pain? Where:				
Is the pain dull ***or*** stabbing?				
Does the pain move around ***or*** is it fixed in one location?				
Does application of heat ***or*** cold reduces the pain or discomfort?				
Does pressure aggravates ***or*** relieves the pain or discomfort?				
Do you experience fluid retention? When?_____ Where?_____				
Do you have any organ prolapse (drop): uterus, intestines, bladder,				
anus, hemorrhoids, varicose veins, ***or*** heavy dragging pains?				
Do you have a scratchy ***or*** sore throat, outside of colds or flues?				
Do you have growths, warts, masses, ***or*** swollen lymph nodes?				
Do you experience head aches ***or*** migraines?				
Pains are: Fixed in one location ***or*** moves around?				
Stabbing ***or*** dull?				
Slight, off & on ***or*** Constant?				
Front **or** back of head ***or*** One-sided?				
Connected to the neck?				
Accompanied by: Heaviness ***or*** Nausea?				
Double vision ***or*** blurry vision?				
Other symptoms?_____				

PAIN & DISCOMFORTS:	**Never**	**Rarely**	**Sometimes**	**Often**
Do you experience heart palpitations (racing heart)? When				
Do you experience dry ***or*** itchy skin ***or*** scalp?				
Does your nose often itch?				
Does any part of your body get numb?				
Which part?_____ When?_____				
Do you get cramps in your thighs ***or*** legs when walking?				
Do your legs cramp up at night?				
Do you experience itchy ***or*** burning sensation in eyes?				
Do you often experience red itchy eyes?				
Do you experience watery ***or*** dry eyes?				

SENSATIONS:	**Never**	**Rarely**	**Sometimes**	**Often**
Do you experience dizziness ***or*** motion sickness?				
Do you often have difficulty maintaining balance?				
Do you have any problems with coordination?				
Have you ever fainted ***or*** passed out? When?				
Have you ever experienced dizziness characterized by violent vertigo, unstable sense of balance accompanied with sudden deafness ***or*** ringing in the ears?				
Do you currently experience ringing in the ears?				
Do you have some loss of hearing?				
Do you experience double ***or*** blurry vision?				
Do you see colored rings around lights ***or*** are you light-sensitive?				
Do you have floaters in your eyes ? (more noticeable when looking at a light colored wall or ceiling)				
Do you wear eye glasses or contacts? Yes No				
Has your vision changed in the last year? Yes No				
Are you Nearsightedness (decreased distance vision) Farsightedness (decreased closeup vision)?				
Do you experience nervous tics, muscle spasms, ***or*** convulsions?				
Do you experience weakness ***or*** tremors in your limbs?				
Do you experience a bitter ***or*** off-taste in your mouth?				
Men: Do you experience impotence, premature ***or*** spontaneous night time ejaculation?				

SLEEP:	**Never**	**Rarely**	**Sometimes**	**Often**
Do have a problem falling asleep?				
Do you have problems staying asleep?				
If you do, do you have a problem getting back to sleep?				
Do you wake up from night sweats ***or*** hot flashes?				
Do you wake up with heart palpitations?				
Do you wake up anxious?				

SLEEP:	**Never**	**Rarely**	**Sometimes**	**Often**
Do you sleep restlessly?				
Dream a lot or have nightmares?				
Do you wake up from dreams ***or*** nightmares?				
Do you sleepwalk?				
Do you have sleep apnea (stop breathing temporarily)?				

BEHAVIOR:	**Never**	**Rarely**	**Sometimes**	**Often**
Do you tend to be more outgoing ***or*** are you more withdrawn?				
Do you tend to be laid-back and take things in stride?				
Do you have lot of ideas but not the energy to follow through?				
Do you tend to be persistent ***or*** do you easily give up?				
Do you find that your thinking is often confused or muddled?				
Do tend to have a poor memory?				
Are you timid ***or*** easily frightened ***or*** easily overwhelmed?				
Do you have a tendency to become obsessed over *trifling* details?				
Do you get easily annoyed ***or*** angry?				
Do you tend to have patience with others ***or*** with yourself?				
Do you tend to feel happy and content?				
Do you get easily depressed?				
Do you tend to feel restless ***or*** nervous ***or*** anxious?				

MISCELLANEOUS	**Never**	**Rarely**	**Sometimes**	**Often**
How often do you have head colds?				
Flues?				
Chest colds?				
Stuffed up nose?				
Sneezing spells?				
Seasonal Allergies?				
Sinus infections?				
Ear aches ***or*** ear infections				
In the last 3 months have you had a fever lasting more than a day?				
Any cold sores ***or*** fever blisters?				
Sores ***or*** cuts that were hard to heal?				
Any swollen lymph nodes in your neck, armpit, ***or*** groin?				
Have you recently been experiencing hair loss?				
Do you experience brittle finger nails?				

IS THERE ANYTHING ELSE THAT HAS NOT BEEN COVERED?_____