

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Polio | <input type="checkbox"/> Vein condition |

III. Patient Profile

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ function):

Temperature: (Kidney Function)

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold fingers | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold toes |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Sweaty Feet | <input type="checkbox"/> Hot body temp. | <input type="checkbox"/> Heat in the hands/feet |
| <input type="checkbox"/> Afternoon flushes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Cold body temp. | <input type="checkbox"/> Heat in the chest |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Thirst | <input type="checkbox"/> Perspire easily | <input type="checkbox"/> Lack of perspiration |
| <input type="checkbox"/> Take water to bed | | | |

Energy: (Lung, Spleen, Kidney Function)

- | | | |
|---|--|--|
| <input type="checkbox"/> General weakness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty keeping eyes open in daytime |
| <input type="checkbox"/> Easily catch colds | <input type="checkbox"/> Low energy | <input type="checkbox"/> Feel worse after exercise |

Blood: (Liver, Spleen, Heart)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> See floating black/gray spots in vision |
|------------------------------------|--|

Heart Function:

- | | | |
|---|---|---|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sores on the tip of the tongue |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Mental confusion | <input type="checkbox"/> Chest pain traveling to shoulder |
| <input type="checkbox"/> Frequent dreams | <input type="checkbox"/> Vivid Dreams | <input type="checkbox"/> Wake un-refreshed |
| <input type="checkbox"/> Drink coffee (# of cups per week: _____) | | |

Lung Function:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Nasal Discharge (Color: _____) |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Dry nose | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Allergies (to what: _____) |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Headache | <input type="checkbox"/> Alternating fever and chills |
| <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Stiff shoulders | <input type="checkbox"/> Generalized achy feeling |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Melancholy | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Smoke cigarettes: (# of cigarettes per day: _____) | |

Spleen Function:

- | | | |
|---|---|--|
| <input type="checkbox"/> Low appetite | <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Abrupt weight gain |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Abdominal gas |
| <input type="checkbox"/> Bruise easy | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Gurgling noise in stomach |
| <input type="checkbox"/> Pensive | <input type="checkbox"/> Over-thinking | <input type="checkbox"/> Prolapsed organs (which organ? _____) |
| <input type="checkbox"/> Worry | | |

Spleen, Stomach, Large Intestine, Small Intestine Function:

- | | | |
|---|---|---|
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Constipated | <input type="checkbox"/> Incomplete bowel movements |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Mucous in stool |
| <input type="checkbox"/> Undigested food in stool | | |

