



Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees), relative to other people do you wear more or less layers, etc.

<p>COLD</p> <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	<p>Thirst for cold / hot drinks</p> <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<p>HOT</p> <input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats When _____ am / pm Where on body _____	<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night
---	--	---	---

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

<p>DRY</p> <input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	<p style="text-align: right; font-size: small;">Where on your body?</p> <input type="checkbox"/> Edema / Swelling _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Itching _____ <input type="checkbox"/> Dandruff	<p>OILY</p> <input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss
---	--	---	--

DIGESTION

<p>DIARRHEA</p> <p>BM: How often? _____ x / every _____ days</p> <p>Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger	<p>CONSTIPATION</p> <input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools
--	--	--	--

ENERGY

<p>LOW</p> <input type="checkbox"/> Sudden energy drop Time of day: _____ am / pm <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy	<p>HIGH</p> <input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week
--	--	---	--

SLEEP

hours per night _____

 Difficulty falling asleep
 Wake _____ x / night @ _____ am / pm
 Wake to urinate How often? _____
 Disturbing dreams
 Restless sleep
 Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

<input type="checkbox"/> Anger	<input type="checkbox"/> Grief
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Joy
<input type="checkbox"/> Worry	<input type="checkbox"/> Fear
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Sadness	<input type="checkbox"/> Indecision

EYES, EARS NOSE THROAT

<input type="checkbox"/> Poor vision	<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Excess earwax
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Phlegm (color _____)	<input type="checkbox"/> Cough

<p>MENSES</p> <p>Age at first menses: _____</p> <p>Length of full cycle: _____ days</p> <p>Length of menses: _____ days</p> <p>Last menses start date: _____ / _____</p> <p># of pregnancies: _____</p> <p># of births: _____ premature _____</p> <p># of abortions / miscarriages: _____</p>	<p>MENOPAUSE</p> <p>Age at last menses: _____</p> <p>Year changes began: _____</p> <input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS)	<input type="checkbox"/> Hot flashes _____ x / day <input type="checkbox"/> Night sweats _____ x / week <input type="checkbox"/> Cramps <input type="checkbox"/> Before bleeding <input type="checkbox"/> First day <input type="checkbox"/> During period <input type="checkbox"/> Clots <input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Loss of sex drive <input type="checkbox"/> Mood changes <input type="checkbox"/> Fatigue w/ menses <input type="checkbox"/> Digestive changes w/ menses <input type="checkbox"/> Midcycle spotting <input type="checkbox"/> Yeast infections <input type="checkbox"/> Birth control pill (hormonal)
--	---	---	--