

Name: _____ Birthdate: _____ Constitution : _____

Circle the answer that best reflects the intensity of each symptom at this time.

0 = Never 1 = Seldom 2 = Occasional 3 = Often

Unit I: DIGESTION

Part A: LOW ACIDITY

- 1. Indigestion 0 1 2 3
- 2. Abdominal Bloating 0 1 2 3
- 3. Feel too full after eating 0 1 2 3
- 4. Constipation 0 1 2 3
- 5. Belching/Burping 0 1 2 3
- 6. Diminished appetite 0 1 2 3
- 7. Stomach growls/ gurgles 0 1 2 3
- 8. Any known food allergies? 0 1 2 3

Part B: HIGH ACIDITY

- 1. Stomach pains just before or after meals 0 1 2 3
- 2. Stomach pains with no apparent reason 0 1 2 3
- 3. Stomach pain relieved by carbonated drinks 0 1 2 3
- 4. Stomach pain relieved by milk / cream 0 1 2 3
- 5. Emotional upset causes stomach pain 0 1 2 3
- 6. Heartburn immediately after meals 0 1 2 3
- 7. Constant need for antacids 0 1 2 3
- 8. "Butterfly feeling" in stomach 0 1 2 3
- 9. Family history of ulcer / gastritis? No Yes
- 10. Ulcer in the past year? No Yes
- 11. Current ulcer? No Yes
- 12. Very dark or black stool? No Yes
- 13. Hot / spicy food cause stomach irritation? No Yes

Unit II: ASSIMILATION

Part A: SMALL INTESTINE

- 1. Stomach cramps 0 1 2 3
- 2. Indigestion immediately after eating 0 1 2 3
- 3. Feel tired after meals 0 1 2 3
- 4. Flatulence (gas) 0 1 2 3
- 5. Constipation / diarrhea (alternating) 0 1 2 3
- 6. Fiber rich diet won't stop constipation 0 1 2 3
- 7. Loose stool 0 1 2 3
- 8. Presence of mucus in stool 0 1 2 3
- 9. Stool poorly formed 0 1 2 3
- 10. Four or more large stools daily 0 1 2 3
- 11. Stools have foul odor 0 1 2 3
- 12. Pain in left side of abdomen 0 1 2 3
- 13. History of pimples, skin eruption? No Yes
- 14. Any known food allergies? No Yes

Part B: LARGE INTESTINE

- 1. Diarrhea 0 1 2 3
- 2. Recurrent infections / colds 0 1 2 3
- 3. History of kidney and/or bladder infection 0 1 2 3
- 4. Yeast infection (including vaginal) 0 1 2 3
- 5. Frequent abdominal cramps 0 1 2 3
- 6. Fingernail and/or toenail fungus 0 1 2 3
- 7. Diarrhea and constipation (alternating) 0 1 2 3
- 8. Chronic constipation 0 1 2 3
- 9. Use of antibiotics in past year? No Yes
- 10. Meat eater? No Yes
- 11. Vision deteriorating rapidly? No Yes

Unit III: PANCREAS

Part A: LOW BLOOD SUGAR

- 1. Dizziness / dimmed vision when standing up suddenly 0 1 2 3
- 2. Strong desire / craving for sweets 0 1 2 3
- 3. Sweets / alcohol promptly relieve headaches 0 1 2 3
- 4. Irritable if a meal is missed or delayed 0 1 2 3
- 5. Hungry most of the time 0 1 2 3
- 6. Constantly anxious, nervous, worrisome 0 1 2 3
- 7. Frequently drowsy, impatient, moody 0 1 2 3
- 8. Need for caffeine to get going 0 1 2 3
- 9. Rapid heartbeat after eating sweets 0 1 2 3
- 10. Hungry 1-3 hours after eating 0 1 2 3
- 11. Restless, poor concentration 0 1 2 3
- 12. Forgetful; poor memory 0 1 2 3
- 13. Feel shaky, weak, or fatigued 0 1 2 3
- 14. Feel better / calmer after eating? No Yes
- 15. Low protein / high carbohydrate diet? No Yes

Part B: HIGH BLOOD SUGAR

- 1. Decreased resistance to infection 0 1 2 3
- 2. Slow healing cuts, wounds, etc. 0 1 2 3
- 3. Night sweats 0 1 2 3
- 4. Heightened thirst 0 1 2 3
- 5. Increased appetite 0 1 2 3
- 6. Eating sweets does not alleviate cravings 0 1 2 3
- 7. Fatigue, mental confusion 0 1 2 3
- 8. Poor, deteriorating eyesight 0 1 2 3
- 9. Itchy skin, boils and/or leg sores 0 1 2 3
- 10. History of diabetes in family? No Yes
- 11. Sugar (glucose) detected in urine? No Yes
- 12. Low protein / high carbohydrate diet? No Yes
- 13. Overweight? No Yes

Unit IV: LIVER / GALLBLADDER

Part A-1: LIVER / GALLBLADDER

- 1. Abdominal pain after eating fatty foods 0 1 2 3
- 2. Pain in the side under right rib cage 0 1 2 3
- 3. Pain or tender big toe 0 1 2 3
- 4. Hard / dry stool (painful to pass) 0 1 2 3
- 5. Stool color is grayish (light in color) 0 1 2 3
- 6. Stool has foul odor 0 1 2 3
- 7. Less than one daily bowel movement 0 1 2 3
- 8. History of constipation 0 1 2 3
- 9. Gray colored skin 0 1 2 3
- 10. Headaches following meals 0 1 2 3
- 11. Recurring sour, bitter taste in mouth 0 1 2 3
- 12. Red blood in stool? No Yes

Part A-2: LIVER / GALLBLADDER

- 1. Yellow sclera (white of the eyes) 0 1 2 3
- 2. Bad breath or body odor 0 1 2 3
- 3. Tired / sleepy after meals 0 1 2 3
- 4. Dandruff 0 1 2 3
- 5. Retain water 0 1 2 3
- 6. Dry skin and/or hair 0 1 2 3
- 7. Eat at fast food restaurants 0 1 2 3
- 8. Impatient, impulsive, easy to anger 0 1 2 3

Part A-2: LIVER / GALLBLADDER (cont)

- 9. Vision problems / red or dry eyes? No Yes
- 10. Have had jaundice or hepatitis? No Yes
- 11. High blood cholesterol and/or low HDL? No Yes

Unit V: URINARY SYSTEM

Part A: KIDNEY / BLADDER

- 1. Constant feeling of a full bladder 0 1 2 3
- 2. Loss of control holding urine 0 1 2 3
- 3. Drip / dribble after urination 0 1 2 3
- 4. Blood or pus in urine (in any amount) 0 1 2 3
- 5. Hazy or cloudy urine 0 1 2 3
- 6. Urine has odor / strong smell 0 1 2 3
- 7. Long intervals between urination 0 1 2 3
- 8. Straining to urinate with scant passage 0 1 2 3
- 9. Awaken in middle of night to urinate 0 1 2 3
- 10. Feeling of fear / insecurity 0 1 2 3
- 11. Dark circles under eyes 0 1 2 3
- 12. Pain or pressure in middle of back 0 1 2 3
- 13. Intermittent pain in urethra 0 1 2 3
- 14. History of bladder infection / cystitis? No Yes
- 15. Recent use of antibiotics – kidney/bladder infections? No Yes
- 16. Recent bladder surgery (including A/P repair) No Yes

Unit VI: THYROID

Part A-1: THYROID

- 1. Sensitivity to cold / wet weather 0 1 2 3
- 2. Hands and feet are cold 0 1 2 3
- 3. Constantly tired / fatigued 0 1 2 3
- 4. Lack of stamina for daily chores 0 1 2 3
- 5. Diagnosis of attention deficit disorder (ADD) 0 1 2 3
- 6. Eyes appear bulging or swollen 0 1 2 3
- 7. Skin is dry (lacks moisture) 0 1 2 3
- 8. Difficulty waking up in the morning 0 1 2 3
- 9. Depressed, apathetic, lethargic 0 1 2 3
- 10. Lack of or diminished sex drive 0 1 2 3
- 11. Irritability / mood swings when eating sweets 0 1 2 3

Part A-2: THYROID

- 12. Constipation? 0 1 2 3
- 13. Gain weight easily? No Yes
- 14. Basal / armpit temperature less than normal? No Yes
- 15. Slow reflexes / reaction time? No Yes
- 16. Infertility / impotency? No Yes
- For women only:*
- 17. Heavy / profuse menstrual bleeding 0 1 2 3
- 18. Premenstrual tension / stress 0 1 2 3

Unit VII: ADRENAL

Part A: ADRENAL

- 1. Unable to tolerate much exercise 0 1 2 3
- 2. Catch colds or get sick easily 0 1 2 3
- 3. Sensitive to air pollutants, chemicals, smoke 0 1 2 3
- 4. Breathing is labored / difficult 0 1 2 3
- 5. Feelings of weakness / shakiness 0 1 2 3
- 6. Moments of depression 0 1 2 3
- 7. Rapid mood swings 0 1 2 3
- 8. Energy lag in morning to mid-afternoon 0 1 2 3
- 9. Need for caffeine to get going 0 1 2 3
- 10. Intermittent constipation 0 1 2 3
- 11. Dark circles beneath the eyes 0 1 2 3
- 12. Dizzy / light headed upon standing 0 1 2 3
- 13. Lack of mental alertness (mental fog) 0 1 2 3

Part A: ADRENAL (cont)

- 14. Retain Water 0 1 2 3
- 15. Insomnia 0 1 2 3
- 16. Eyes sensitive to bright / direct light 0 1 2 3
- 17. Use cortisone, prednisone, steroids No Yes

Unit VIII: FEMALE

Part A: SYMPTONS DURING MENSTRUATION

- 1. Monthly weight gain 0 1 2 3
- 2. Feeling of depression / anxiety 0 1 2 3
- 3. Moodiness / irritability / anger 0 1 2 3
- 4. Bloating / swelling 0 1 2 3
- 5. Nausea / vomiting 0 1 2 3
- 6. Tenderness in breast area 0 1 2 3
- 7. Leg cramps / tenderness 0 1 2 3
- 8. Lower back ache 0 1 2 3
- 9. Headaches 0 1 2 3
- 10. Easily distracted 0 1 2 3
- 11. Asthma / bronchitis attacks? No Yes
- 12. Suicidal feelings? No Yes

Part B: AMENORRHEA (ABSENCE OF MENSTRUATION)

- 1. Vaginal itching / discharge 0 1 2 3
- 2. Missed periods 0 1 2 3
- 3. Crave sweets or additional food 0 1 2 3
- 4. More than 1 cycle per month 0 1 2 3
- 5. Low or no desire for sex? No Yes
- 6. Pain during intercourse? No Yes
- 7. Menstruation started after age 15? No Yes
- 8. Unable to get pregnant? No Yes
- 9. Number of miscarriages (if any) 0 1 2 3+
- 10. Number of abortions (if any) 0 1 2 3+

Part C: DYSMENORRHEA (PAINFUL MENSTRUATION)

- 1. Anxiety about arrival of menstrual cycle 0 1 2 3
- 2. Low abdominal pain 0 1 2 3
- 3. Dull pain radiation to lower back or legs 0 1 2 3
- 4. Menstrual pain 0 1 2 3
- 5. Menstrual pain becomes progressively worse 0 1 2 3
- 6. Pain and cramps without blood flow 0 1 2 3
- 7. Light, sparse blood flow 0 1 2 3
- 8. Heavy menstrual bleeding 0 1 2 3
- 9. Nausea / vomiting prior to or during periods 0 1 2 3
- 10. Need to lie down first 1 or 2 days of period 0 1 2 3
- 11. Increased urinary frequency 0 1 2 3
- 12. Pelvic soreness 0 1 2 3
- 13. Diarrhea associated with menstruation 0 1 2 3
- 14. Headache during periods 0 1 2 3
- 15. Abdominal bloating 0 1 2 3
- 16. Craving for sweets (especially chocolate) 0 1 2 3

Part D: FIBROUS TISSUE AND CYSTS

- 1. Irregularities / soreness / lumps in vaginal area 0 1 2 3
- 2. Pain in ovaries 0 1 2 3
- 3. Retain water 0 1 2 3
- 4. Swollen feeling 0 1 2 3
- 5. Premenstrual breast pain or discomfort 0 1 2 3
- 6. Breast lumps? No Yes
- 7. Recent abnormal pap smear? No Yes
- 8. Family history of breast cancer? No Yes
- 9. Ovarian / uterine cyst? No Yes
- 10. Recent use of hormones? No Yes
- 11. Recent use of birth control device / medication? No Yes

Part E: CHANGE OF LIFE (AGE 35 AND OVER)

1. Sweating throughout the day	0	1	2	3
2. Night sweats	0	1	2	3
3. Hot flashes	0	1	2	3
4. Mood swings	0	1	2	3
5. Insomnia / light sleeper	0	1	2	3
6. Craving for sweets (especially chocolate)	0	1	2	3
7. Heavy bleeding two weeks at a time	0	1	2	3
8. Dryness of pubic hair and vaginal area	0	1	2	3
9. Vaginal pain / itching	0	1	2	3
10. Painful intercourse	0	1	2	3
11. Hysterectomy?	No	Yes		
12. Osteoporosis?	No	Yes		

Unit IX: MALE**Part A: PROSTATE**

1. Weakened urinary flow	0	1	2	3
2. Burning / painful urination	0	1	2	3
3. Bladder feels full	0	1	2	3
4. Blood / pus in urine (any amount)	0	1	2	3
5. Awakening to urinate during the night	0	1	2	3
6. Drip / dribble after urination	0	1	2	3
7. Fatigue in legs or lower back	0	1	2	3
8. Decreased libido / sex drive	0	1	2	3
9. Pain or discomfort upon ejaculation	0	1	2	3

Part B: MALE REPRODUCTION

1. Coldness / pain in genital area	0	1	2	3
2. Difficulty in maintaining an erection	0	1	2	3
3. Fear / anxiety about sexual intimacy	0	1	2	3
4. Premature ejaculation	0	1	2	3
5. Weak kneel / lower back	0	1	2	3
6. Infertility?	No	Yes		
7. Varicose veins on scrotum?	No	Yes		
8. Sperm count low?	No	Yes		
9. Lack of / diminished sex drive?	No	Yes		

Part C: GENITAL INFECTION

1. Genitals swollen and/or tender	0	1	2	3
2. Groin area swollen / inflamed	0	1	2	3
3. Multiple sexual partners	0	1	2	3
4. Discharge from penis?	No	Yes		
5. Rash on penis / pubic area?	No	Yes		
6. Current venereal disease?	No	Yes		
7. Venereal disease in the past?	No	Yes		

Unit X: CIRCULATORY SYSTEM**Part A: HEART**

1. Nervous / jittery for no apparent reason	0	1	2	3
2. Calf muscles cramp when walking	0	1	2	3
3. Arrhythmia / chest pain when walking	0	1	2	3
4. Shortness of breath during minor activity	0	1	2	3
5. Rapid heartbeat during minor activity	0	1	2	3
6. Palpitations / erratic heartbeat	0	1	2	3
7. Numbness / pain in left arm	0	1	2	3
8. Heaviness in legs	0	1	2	3
9. Edema / swelling of feet and ankles	0	1	2	3
10. Regular exercise?	0	1	2	3
11. Frequent aerobic exercise?	No	Yes		
12. Red, swollen nose?	No	Yes		
13. Usual resting heart rate	Slow	Norm.	Fast	

Part B: CIRCULATION

1. Get angry / excited easily	0	1	2	3
2. Headaches / migraines for no apparent reason	0	1	2	3
3. Poor concentration / foggy brain	0	1	2	3
4. Ringing in ears	0	1	2	3
5. Cold extremities (hands / feet)	0	1	2	3
6. Numbness in extremities (hands / feet)	0	1	2	3
7. Blushing for no apparent reason	0	1	2	3
8. Speech slurred / sloppy	0	1	2	3
9. Calf muscles cramp when walking	0	1	2	3
10. Poor circulation	0	1	2	3
11. Systolic and diastolic pressures widely separated?	No	Yes		
12. Lower ear lobe has vertical crease?	No	Yes		
13. Heart attack?	No	Yes		
14. History of stroke?	No	Yes		
15. Resting blood pressure	Low	Norm	High	

Part C: HIGH BLOOD PRESSURE

1. Pain in back of head upon arising in the AM	0	1	2	3
2. Dizziness / lightheadedness / vertigo	0	1	2	3
3. Rapid pulse / shortness of breath	0	1	2	3
4. Easily tired by minor exertion	0	1	2	3
5. Visual disturbance	0	1	2	3
6. Exercise regularly?	No	Yes		
7. Blood pressure higher than it should be?	No	Yes		
8. Systolic and diastolic pressures close to each other?	No	Yes		

Part D: LYMPHATIC

1. Need to clear throat, particularly in AM	0	1	2	3
2. Swelling in throat / neck	0	1	2	3
3. Skin irritation / rash	0	1	2	3
4. Pressure / congestion in or behind ears	0	1	2	3
5. Do you exercise regularly?	No	Yes		
<i>For women only:</i>				
6. Nodules or tenderness in breasts	0	1	2	3
7. Swelling in feet / ankles upon waking in AM	0	1	2	3
8. Puffiness beneath eyes in the morning	0	1	2	3

Unit XI: RESPIRATORY SYSTEM**Part A: RESPIRATORY SYSTEM**

1. Shortness of breath / labored breathing	0	1	2	3
2. Chest tightness / pain	0	1	2	3
3. Recurring / chronic cough	0	1	2	3
4. Coughing up phlegm or blood	0	1	2	3
5. Chest colds	0	1	2	3
6. Sensitive to smog / perfumes, etc	0	1	2	3
7. Live / work with people who smoke	0	1	2	3
8. Smoker – currently or in past 3 years?	No	Yes		
9. Chronic lung infections?	No	Yes		
10. Exposure to chemicals, pesticides or radiation?	No	Yes		

Unit XII: IMMUNE SYSTEM**Part A: LOW-FUNCTION (HYPO IMMUNITY)**

1. Bleeding or sensitive gums	0	1	2	3
2. Runny / sniffy nose	0	1	2	3
3. Nose bleeds for no apparent cause	0	1	2	3
4. Loss of sense of smell or taste	0	1	2	3
5. Chest and throat infections	0	1	2	3
6. Fever blisters, cold sores	0	1	2	3
7. Wounds heal slowly	0	1	2	3
8. Hair thinning / falling out / slow growing	0	1	2	3
9. Ear infection / congestion	0	1	2	3
10. Slow recovery from cold or flu	0	1	2	3

Part A: LOW-FUNCTION (HYPO IMMUNITY)(cont)

- 11. Catch colds / flu easily, despite precautions 0 1 2 3
- 12. Skin on back of arms is rough / bumpy 0 1 2 3
- 13. Lymph glands swell? No Yes

Part B-1: EXCESSIVE FUNCTION (HYPER IMMUNITY)

- 1. Known food sensitivity / allergy 0 1 2 3
- 2. Some foods cause illness / anxiety / depression 0 1 2 3
- 3. Stomach pain / G.I. tract discomfort 0 1 2 3
- 4. Swallowing tablets is difficult 0 1 2 3
- 5. Skin disorder / rashes? No Yes
- 6. Bronchitis / asthma / chronic lung problems? No Yes
- 7. Recurring migraine headaches? No Yes
- 8. Mucus in throat / chest 0 1 2 3
- 9. Low grade fever from time to time 0 1 2 3
- 10. Swollen / inflamed joints, body aches 0 1 2 3
- 11. Swollen or sore tongue 0 1 2 3
- 12. Eye itch / puffiness / discharge? No Yes
- 13. Ear stuffy / congested 0 1 2 3
- 14. Sinus infection 0 1 2 3

Part B-2: EXCESSIVE FUNCTION (HYPER IMMUNITY)

- 15. Runny nose / post nasal drip 0 1 2 3
- 16. Alternating diarrhea and constipation 0 1 2 3
- 17. Bed wetting? No Yes
- 18. Attention deficit / hyperactivity? No Yes
- 19. Use aspirin, Tylenol, ibuprofen? No Yes
- 20. Use cortisone, prednisone, steroids? No Yes
- 21. Mouth breather? No Yes

Unit XIII: BONE

Part A: BONE INTEGRITY

- 1. Cavities / dental weaknesses 0 1 2 3
- 2. Bones sore / painful 0 1 2 3
- 3. Pain in joints / extremities 0 1 2 3
- 4. Eat meat at most meals? No Yes
- 5. 3+ cups/day of carbonated beverages? No Yes
- 6. Gingivitis / gum sensitivity? No Yes
- 7. Use antacids at least once a day? No Yes
- 8. Presently wear dentures? No Yes
- 9. Any known bone deformities? No Yes
- 10. Diagnosed with arthritis / rheumatism? No Yes
- 11. Diagnosed with osteoporosis? No Yes
- 12. Recent bone fracture (past 2 years)? No Yes
- For women only:*
- 13. Post menopausal? No Yes

Unit XIV: SOFT TISSUE

Part A: MUSCLE

- 1. Muscle cramps 0 1 2 3
- 2. Muscle spasms 0 1 2 3
- 3. Tension in shoulder muscles 0 1 2 3
- 4. Pain in neck (fibromyalgia) 0 1 2 3
- 5. Unable to sit for long periods 0 1 2 3
- 6. Still upon awakening 0 1 2 3
- 7. Pain / cramps in arms, legs, hands and feet 0 1 2 3
- 8. Fibromyalgia? No Yes

Part B: CONNECTIVE TISSUE

- 1. Injured tendons / ligaments 0 1 2 3
- 2. Double jointed 0 1 2 3
- 3. Aching joints 0 1 2 3
- 4. Back pain 0 1 2 3
- 5. Tendonitis 0 1 2 3
- 6. Knees / elbows swollen 0 1 2 3

Part B: CONNECTIVE TISSUE (cont)

- 7. Bursitis 0 1 2 3
- 8. Slipped / herniated disc? No Yes
- 9. Height loss? No Yes
- 10. Bruise / injure easily? No Yes

Unit XV: NERVOUS SYSTEM

Part A: NERVOUS SYSTEM

- 1. Tingling sensation under the skin 0 1 2 3
- 2. Noises / ringing in ears 0 1 2 3
- 3. Loss of balance / vertigo 0 1 2 3
- 4. Abnormally exhausted 0 1 2 3
- 5. Light headedness / dizziness 0 1 2 3
- 6. Nervousness / restlessness 0 1 2 3
- 7. Grip strength weaker than usual 0 1 2 3
- 8. Arms and legs feel heavy 0 1 2 3
- 9. Numbness in hands and feet 0 1 2 3
- 10. Heavy headed feeling 0 1 2 3
- 11. Tremor in hands 0 1 2 3
- 12. Clumsiness / bad coordination 0 1 2 3
- 13. Convulsions / seizures? No Yes
- 14. Have shingles / herpes? No Yes
- 15. Accident prone? No Yes
- 16. Need for 10 or more hours of sleep? No Yes
- 17. Noticeable loss of muscle mass? No Yes

Unit XVI: SLEEP

Part A: SLEEP PATTERNS

- 1. Nightmares / intense dreams 0 1 2 3
- 2. Insomnia 0 1 2 3
- 3. "Toss and turn" sleeper 0 1 2 3
- 4. Restless legs when laying down 0 1 2 3
- 5. Currently using a sleep aid? No Yes
- 6. Wake up frequently during the night? No Yes
- 7. Wake early, can't fall back to sleep? No Yes
- 8. Sleep walk / talks in sleep? No Yes

