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PATIENT NAME: _____
Date: _____

It is very important in Chinese Medicine to know how long a patient has experienced symptoms. Please indicate in a scale from 1 to 3 how often do you feel these symptoms:

1: sometimes; 2: often; 3: chronic or major concern

Water Element	Wood Element	Fire Element
Hearing loss ☐	Headache ☐	Dry scalp ☐
Dizziness ☐	Migraines ☐	Skin eruptions, rashes ☐
Low back pain ☐	Ringing in the ears ☐	Cysts, tumors ☐
Neck pain ☐	Poor eyesight ☐	Ear infections ☐
Sinus congestion ☐	Eye infections ☐	Sore throat, tonsillitis ☐
Edema ☐	Dry eyes ☐	Lymphatic swelling ☐
Darkness under eyes ☐	Eczema ☐	Hot palms & soles ☐
Emotional instability ☐	Shingles ☐	Heart palpitations ☐
Aversion to cold ☐	Herpes Simplex ☐	Aversion to heat ☐
Hair thinning or loss ☐	Warts ☐	Bitter taste ☐
Pre-mature aging ☐	Nervousness ☐	Gum problems ☐
Frequent urination ☐	Convulsions ☐	Nose bleed ☐
Kidney stones ☐	Spasms ☐	Facial redness ☐
Perspire very easily ☐	Irritability ☐	Itching/ burning skin ☐
Weakness of legs/knees ☐	Constipation ☐	Hot hands/feet ☐
Asthmatic cough ☐	Hemorrhoids ☐	Thirst ☐
Rapid weight change ☐	Hepatitis ☐	Dark urine ☐
Loose teeth ☐	Irregular Menstruation ☐	Night sweats ☐
Reduced sexual energy ☐	Painful Menstruation ☐	
Thyroid problems ☐	Ulcer ☐	
Diabetes ☐	Vomiting ☐	
	Gallstones ☐	
	Indecisiveness ☐	
	Fullness below ribs ☐	
	Shoulder/Neck tension ☐	
	Insomnia 11pm-3am ☐	

Earth Element	Metal Element	Other
Indigestion ☐ Flatulence ☐ Food Allergy ☐ Stomach ache/ulcer ☐ Diarrhea ☐ Anemia ☐ Halitosis ☐ Mouth Sores ☐ Heartburn ☐ Strong Appetite ☐ Weak Appetite ☐ Nausea ☐ Abdominal Bloating ☐ Low Body Weight ☐	Bronchitis ☐ Asthma ☐ Shallow breathing ☐ Cough ☐ Sinus Congestion ☐ Nasal Infections ☐	Fatigue ☐ Arthralgia ☐ Sciatica/Nerve pain ☐ Cold hands/Feet ☐ Tendonitis ☐ Bursitis ☐