

DIAGNOSIS

Yes

No

KIDNEY DEFICIENCY/YIN (Ki Yin-)

Do you have lower back weakness, soreness or pain, or knee problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have ringing in your ears or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair prematurely gray?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mid-cycle fertile cervical mucus scanty or missing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles around or under your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as afraid a lot?	<input type="checkbox"/>	<input type="checkbox"/>
Is your tongue lacking in coating? Does it appear shiny or peeled?	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS

Yes

No

KIDNEY DEFICIENCY/YANG (Ki Yan-)

Do you have lower back pain premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Is your low back sore or weak?	<input type="checkbox"/>	<input type="checkbox"/>
Are your feet cold, especially at night?	<input type="checkbox"/>	<input type="checkbox"/>
Are you typically colder in nature than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Is your libido low?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often fearful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up at night or early morning because you have to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently, and is the urine dilute and/or profuse?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early morning loose, urgent stools?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have profuse vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood tend to be dull in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel cold cramps during your period that respond to a heating pad?	<input type="checkbox"/>	<input type="checkbox"/>
Is your tongue pale and moist?	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS**SPLEEN DEFICIENCY (Sp-)**

	<u>Yes</u>	<u>No</u>
Are you often fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Is your energy lower after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated after eating?	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose stools, abdominal pain, or digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are your hands and feet cold?	<input type="checkbox"/>	<input type="checkbox"/>
Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heaviness or groggy in the head?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot without exerting yourself?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel dizzy, lightheaded, or have visual changes when you stand up fast?	<input type="checkbox"/>	<input type="checkbox"/>
Is your menstruation thin, watery, profuse or pinkish in color?	<input type="checkbox"/>	<input type="checkbox"/>
Are you more tired around ovulation or menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever spot a few days or more before your period comes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with uterine prolapse?	<input type="checkbox"/>	<input type="checkbox"/>
Are your menstrual cramps accompanied by a bearing down sensation on your uterus?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often sick or do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look swollen, with teeth marks on the sides?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pale, yellowish complexion?	<input type="checkbox"/>	<input type="checkbox"/>

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No

BLOOD DEFICIENCY (BI-)

(this category does not necessarily equate with anemia)

Are your menses scanty and/or late?

Do you have dry, flaky skin?

Are you prone to getting chapped lips?

Are your fingernails or toenails brittle?

Are you losing hair on your head (not in patches, but all over)?

Is your hair brittle or dry?

Do you have diminished nighttime vision?

Do you get dizzy or lightheaded around your period?

Are your lips, the inner side of your lower eyelids, or tongue pale in color?

DIAGNOSIS

Yes

No

BLOOD STASIS (BI X)

(often associated with blood deficiency symptoms)

Is your menstrual flow ever brown or black in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel midcycle pain around your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have painful, unmovable breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience periodic numbness of your hands and feet (especially at night)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose or spider veins?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have red hemangiomas (cherry red spots) on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Does your complexion appear dark and “sooty” or dirty?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain clots?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with endometriosis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>
Is your lower abdomen tender to palpation (resisting touch)?	<input type="checkbox"/>	<input type="checkbox"/>
Can you feel any abnormal lumps in your lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have piercing or stabbing menstrual cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look very dark?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots on your tongue?	<input type="checkbox"/>	<input type="checkbox"/>
Are the veins beneath your tongue twisty and tortuous?	<input type="checkbox"/>	<input type="checkbox"/>
Do you see dark spots in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>

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No

LIVER QI STAGNATION (Lv Qi X)

Are you prone to emotional depression?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to anger and/or rage?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become irritable premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel irritable around ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Does it feel like your ovulation lasts longer than it should?	<input type="checkbox"/>	<input type="checkbox"/>
Are your breasts sensitive/sore at ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience nipple pain or discharge from your nipples?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of premenstrual breast distention or pain?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with elevated prolactin levels?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become bloated premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Are your pupils usually dilated and large?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep at night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience heartburn or wake up with a bitter taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your menses painful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your menstrual cramps in the external genitalia?	<input type="checkbox"/>	<input type="checkbox"/>
Is the menstrual blood thick and dark or purplish in color?	<input type="checkbox"/>	<input type="checkbox"/>
Is your tongue dark or purplish in color?	<input type="checkbox"/>	<input type="checkbox"/>

<u>DIAGNOSIS</u>	<u>Yes</u>	<u>No</u>
HEART DEFICIENCY (Ht-)		
<i>(often associated with heat signs)</i>		
Do you wake up early in the morning and can't get back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get heart palpitations, especially when anxious?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>
Do you seem low in spirit or lacking in vitality?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you fidget?	<input type="checkbox"/>	<input type="checkbox"/>
Is the tip of your tongue red?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a crack in the center of your tongue that extends to the tip?	<input type="checkbox"/>	<input type="checkbox"/>

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EXCESS HEAT (^H)		
Is your pulse rate rapid?	<input type="checkbox"/>	<input type="checkbox"/>
Are your mouth and throat usually dry?	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave icy, cold drinks?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel warmer than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up sweating?	<input type="checkbox"/>	<input type="checkbox"/>
Do you break out with red acne (especially premenstrually?)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a short menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal irritation or rashes?	<input type="checkbox"/>	<input type="checkbox"/>

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DAMPNESS (D) (includes Phlegm – condensed dampness)		
Do you feel tired and sluggish after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have fibrocystic breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cystic or pustular acne?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have urgent, bright, or foul smelling stools?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain stringy tissue or mucus?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infections and vaginal itching?	<input type="checkbox"/>	<input type="checkbox"/>
Do your joints ache, especially with movement?	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?		
Do you have a wet, slimy tongue?	<input type="checkbox"/>	<input type="checkbox"/>

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DAMP HEAT (DH)		
Do you have signs of heat and/or dampness as indicated earlier?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have foul smelling, yellow or greenish vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?	<input type="checkbox"/>	<input type="checkbox"/>

<u>DIAGNOSIS</u>	<u>Yes</u>	<u>No</u>
COLD UTERUS (CW)		
Do You fit the Kidney Yang deficiency category?	<input type="checkbox"/>	<input type="checkbox"/>
Do you fall into the Blood stasis pattern?	<input type="checkbox"/>	<input type="checkbox"/>
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	<input type="checkbox"/>	<input type="checkbox"/>

