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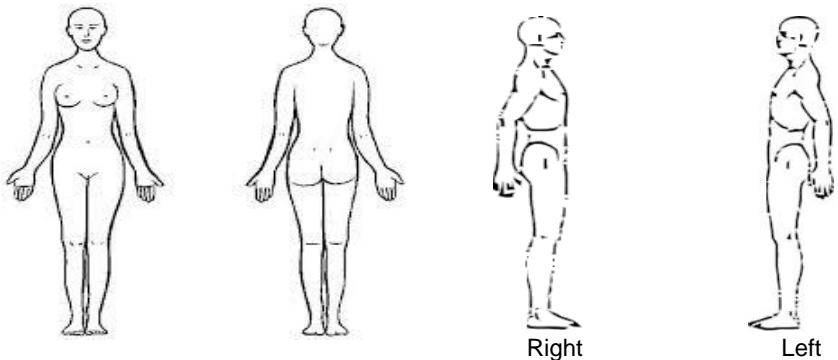
Chinese Medicine Symptom Checklist

Name: _____ Date: _____

Please check any of the following symptoms you experience frequently or have a tendency towards.

- | | | |
|---|--|---|
| <input type="checkbox"/> Fatigue/Low Energy | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Tired after eating | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Low appetite | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Low sex drive |
| <input type="checkbox"/> Strong appetite | <input type="checkbox"/> Sores on the tongue | <input type="checkbox"/> High sex drive |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Startle easily | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Laugh inappropriately | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Abdominal bloating | | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Heartburn/Reflux | | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Frequent irritability/Frustration | <input type="checkbox"/> Ringing in ear |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Depression/Tendency to feel sad | <input type="checkbox"/> Wear socks to bed |
| <input type="checkbox"/> Frequent hiccups or belching | <input type="checkbox"/> Frequent sighing | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Flatulence | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Congenital abnormalities |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain under the ribcage | |
| <input type="checkbox"/> Excessive vaginal discharge | <input type="checkbox"/> Floaters | |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Can't see well at night | |
| <input type="checkbox"/> Tendency to worry/obsess | <input type="checkbox"/> Red eyes | Other symptoms: |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Wake between 1-3am | |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Trouble falling asleep | |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Dizziness | |
| | <input type="checkbox"/> Tight muscles | |
| | <input type="checkbox"/> Painful periods | |
| <input type="checkbox"/> Recurrent colds/Infections | <input type="checkbox"/> Irregular periods | |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Inability to cry | |
| <input type="checkbox"/> Allergies | | |
| <input type="checkbox"/> Sweat easily | | |
| <input type="checkbox"/> Do not sweat | | |
| <input type="checkbox"/> Blood or mucus in stool | | |
| <input type="checkbox"/> Pain in the teeth or gums | | |
| <input type="checkbox"/> Skin problems | | |
| <input type="checkbox"/> Shortness of breath | | |
| <input type="checkbox"/> People often ask you to speak up | | |
| <input type="checkbox"/> Feel Sad | | |

Circle areas of pain, discomfort, and/or tension



Right

Left