East Acupuncture Wellness Boutique

2296 US-70, Swannanoa NC 28778
828.458.4139
info@eastacupuncturewb.com
www.eastacupuncturewb.com

- Initial Acupuncture Treatment and Health History Consultation $100
- Follow-up Acupuncture Treatment $80
- Facial Rejuvenation Treatment $140 (Packages of 6,12,15 at reduced costs)
- Mini Facial & Acupuncture Treatment $100
- Initial Herbal/Nutritional Consultation $50
- Follow Up Herbal/Nutritional Consultation $30
- Body Cupping/Moxa/Gua Shua (No Needle Treatment) $40
- Facial Cupping/Gua Sha and Herbal Mask Treatment $50
- Add Facial Cupping/Gua Sha to any Non-Cosmetic Treatment $25
- Herbal medicine varies in price and is a separate cost from treatments

Scheduling and Payment Policies

- A 24 hour notice is required for cancellation, otherwise you will be billed for the full cost of the appointment
- If you are late to your appointment, that appointment will be shortened in order to complete the treatment at the scheduled time.
- Full payment is expected at time of service. We accept cash, check, and major credit cards. There is a $25 fee for returned checks.
- We do not accept Insurance at this time. A receipt for your office visit with all required coding will be provided upon request; you have the option to check with your insurance carrier to see if reimbursement is possible.

Your Arrival

My Address is 2296 US-70, in the blaze next to PSA Pharmacy and across stem street from Ingles. There is plenty of parking! Upon arriving, the office manager will greet you and instruct you on which room to enter.

Preparation

When possible, please print out the Initial Health History Forms, and fill them out before coming to your first appointment. If you are unable to print the forms, please arrive 15 minutes in advance of your scheduled appointment time to fill out the forms. Also, please remember to provide a list of any and all medications and or supplements that you are currently taking (with dosage). We request that you eat a snack or a small meal with in two hours your scheduled treatment time.

Your treatment

Treatments take place in a peaceful, private, comfortable environment. Your visit will begin by discussing health history and your specific goals for treatment, and in addition the intake will include pulse taking and tongue observation. Upon assessing your health condition, I may select from a variety of techniques to complement your acupuncture treatment. These techniques include: tui na massage, cupping, gua sha, moxibustion heat therapy, electro acupuncture or qi gong rehabilitation. Your treatment may also include dietary and exercise planning that will complement your acupuncture. Treatments will range from 60-90 minutes. To get the most out of your treatment, please take time to relax and reflect both during and after. Following treatment, it is best to keep work or exercise to a minimum for several hours. My goal is to provide you with the knowledge and tools to support your healing and I encourage patient participation with any questions and feedback.

Herbal Medicine

Chinese herbal medicine is tailored to the needs of each patient and used to treat both acute and chronic conditions. Primary options for herbal treatments are the use of teas, tinctured liquid extracts, teapills, powders, topical liniments and patches and essential oils. I may recommend herbal medicine, which you may choose to purchase

ACKNOWLEDGEMENT OF RECEIPT OF CLINIC POLICIES

I have read, understood, and agree to the office policies for healthcare services at Ashley Kuper, L.Ac.

_____

Print Signature Date

We greatly appreciate your support and involvement in EAWB.. We look forward to providing you with an excellent healthcare experience. Suggestions, questions and concerns may be directed to your acupuncturist or the receptionist

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INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture, adjunct techniques and herbal medicine by the licensed acupuncturists of Ashley Kuper, L.Ac.. I understand that acupuncturists practicing in the state of North Carolina are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner. I understand that I may refuse any of the following treatments at any time:

Acupuncture: I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms and, very rarely, organ puncture, nerve damage or infection.

Moxibustion: Moxibustion is the burning of the Chinese herb Ai Ye (Mugwort leaf) indirectly or directly on the surface of the skin, intending to warm and stimulate qi and blood via activating certain acupuncture points. You and the licensed practitioner will communicate on temperature sensitivity during treatment, however there is a mild risk of burning or scarring from the use of moxa.

Electro-Acupuncture: I understand that I may receive electro-acupuncture, which involves the stimulation of acupuncture points with a mild electric current. This treatment is stimulating but not typically painful or shocking. I am aware that certain adverse side effects may result from this treatment., including, but not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

Gua Sha/Cupping: I understand that I may receive gua sha or cupping as part of my treatment. Gua Sha involves repeated pressured strokes over oiled skin with a smooth edge, most often a ceramic Chinese soupspoon. Cupping applies localized suction to the skin with glass cups, drawing the superficial muscle layer into the cup. Both are used to treat pain, relieve stagnation, stimulate the respiratory system, and release heat from the body. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, soreness, on rare occasions blistering and the possible aggravation of symptoms existing prior to treatment.

Acupressure/Massage: I understand that I may receive acupressure or massage. I am aware that certain adverse side effects may result, including but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: I understand that Chinese herbs may be recommended as part of my treatment. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These may include, but are not limited to: changes in bowel movement, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. If I associate any concerns with the use of the herbal substances, I should stop use immediately and call my acupuncturist.

Dietary & Exercise Advice: In conjunction with my treatment, I may be given advice and suggestions concerning changes in diet or exercise routine. Food therapy is an extremely effective means of self-healing, disease prevention and resolution of chronic and acute conditions. Changing eating habits is difficult and I may experience resistance, irritability, change in bowel movements, change in energy level and possible aggravation of symptoms. Suggestions concerning physical activity and exercises may also be included in my treatment. I will communicate with my practitioner about any difficulties I may have with specific dietary or exercise recommendations.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturists before proceeding with acupuncture or herbal medicine.

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature of Patient/Guardian/Personal Representative:

Date:

Printed Name of Patient/Guardian/Personal Representative:

Relationship to Patient:

Printed Name of Patient, if different from signer above:

Date:

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NOTICE OF PRIVACY POLICIES (HIPAA)

The Clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose protected health information (PHI) about you for the treatment, payment, and healthcare operations. PHI is information about you that may identify you and relates to your past, present, and future physical or mental health or condition and related to health care services. You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

The Clinic will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you.

Disclosure

The Clinic may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information:
Contact: East Acupuncture Wellness Boutique
Telephone: 828.458.4139
Address: 2296 US-70, Swannanoa NC 28778

To send a written complaint to the U.S. Department of Health and Human Services:
DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building, Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services at the Clinic.

Patient's Signature: _____ Date: _____

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Fertility History

Age at which menses began _____ **Have your cycles changed since they began?** _____

How?

Do you ovulate on your own? _____ **On what day of your cycle?** _____

Do you experience fertile cervical fluids? _____

Do you experience ovulation pain? _____

Do your breasts get tender at/during ovulation? _____

Do you get premenstrual low back pain? _____

Do your bowel movements become loose at the beginning of your period? _____

Are your periods painful? _____

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? (Light, Normal, or Heavy) _____

What color is the blood? (Light Red, Red, Dark Red, Purple, Brown, or Black) _____

Is there clotting? _____

Do you have premenstrual tension? _____

Does your face break out before or during your period? _____

Do you experience premenstrual headaches? _____

Do your breasts become tender premenstrually? _____

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Do you spot between periods? _____

Are your menstrual cycles spaced irregularly? _____

How many days are there from one period to the next? _____

Date of last menstrual period? _____

Have you had fertility treatments? _____

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medications to help you ovulate? _____

When? _____ **How long?** _____

Have your fallopian tubes been evaluated medically? _____

What are the results? _____

Have you had any tubal operations? _____

Have you had hormone laboratory tests performed? _____

What are the results? _____

Do you have a single partner with whom you have been trying to conceive? _____

How long have you been married or living together? _____

Has he had a fertility workup? _____

What are the results? _____

Is your partner supportive of your wish to conceive? _____

How many pregnancies have you had? **Number** _____ **Years** _____

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How many children do you have? **Number** _____ **Years** _____

How many abortions have you had? **Number** _____ **Years** _____

How many miscarriages have you had? **Number** _____ **Years** _____

How many times has a D&C been performed? **Number** _____ **Years** _____

Have you ever had an abnormal pap smear? _____

Have you ever had a cervical biopsy, operation, cauterization, or conization? _____

Have you ever had a venereal disease? _____

Have you ever been diagnosed with a chlamydial infection? _____

Do you get yeast infections regularly? _____

Do you have chronic vaginal discharge? _____

Do you have any sores on your genitals? _____

Have you ever had pelvic inflammatory disease? _____

Were you treated for it? _____

How?

Date of last pap smear? _____

Have you ever been diagnosed with uterine fibroids or polyps? _____

Have you ever been diagnosed with endometriosis? _____

Have you ever been diagnosed with pelvic adhesions? _____

Have you ever been diagnosed with any pelvic abnormalities? _____

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How heavy is your sexual energy? (Low, Normal, High) _____

Do you douche regularly? _____ **With what?** _____

Do you use vaginal lubricants? _____

Are you more than 20% over your ideal body weight? _____

Do you have a stressful occupation? _____

Do you exercise regularly? _____

Do you have excessive facial hair? _____

Do you have excessively oily skin? _____

Have you experienced excessive loss of head hair? _____

Have you noticed discharge from your nipples? _____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? _____

Have you been exposed to any known environmental toxins or hormones? _____

Are you presently taking steroids? _____

Have you taken oral contraceptives? _____

When? _____ **How long?** _____

Have you ever had an IUD? _____

When? _____ **How long?** _____

Have you taken other forms of hormonal birth control? _____

When? _____ **How long?** _____

How long have you been trying to conceive? _____

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Have you had a diagnosis relating to infertility? _____

What was it? _____

Have you taken any medications for gynecological conditions other than contraceptives? (Please List Below)

1. Medication _____ **How long?** _____

Reason?

2. Medication _____ **How long?** _____

Reason?

3. Medication _____ **How long?** _____

Reason?

4. Medication _____ **How long?** _____

Reason?

5. Medication _____ **How long?** _____

Reason?

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Medical History

Major Health Complaint/Problem?

How did this condition develop?

How long has this condition persisted? _____

Is there anything that makes it better? _____

Is there anything that makes it worse? _____

Have you ever received treatment for this condition? _____

If yes, when and where? _____

By whom? _____

What was the diagnosis? _____

What kind of treatment did you receive? _____

What were the results of the treatment? _____

List any substances you are allergic to: _____

List any medications you are currently taking (other than the medications listed in the Fertility History form):

1. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

2. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

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3. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

4. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

5. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

6. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

7. Medicine _____ **Strength?** _____

Dosage? _____ **How Long?** _____

List any major surgeries you have had:

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Date _____ **Surgery** _____

Significant Trauma (Auto accidents, falls, etc.?)

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Significant illnesses:

_____ Arthritis
_____ Asthma
_____ Autoimmune Disease
_____ AIDS
_____ Cancer
_____ Connective Tissue Disease
_____ Diabetes
_____ Gallstones
_____ Heart Disease
_____ Hepatitis
_____ Hypertension
_____ Kidney Stones
_____ Rheumatic Fever
_____ Ruptured Appendix
_____ Seizures
_____ Thyroid Disease
_____ Venereal Disease

Health History

Please indicate any symptoms you have or have had in the past year.

General

_____ Chills
_____ Low energy
_____ Dizziness
_____ Allergies
_____ Fatigue
_____ Fevers
_____ Excess thirst
_____ Insomnia
_____ Nervousness
_____ Numbness
_____ Sweat spontaneously
_____ Night sweating
_____ Lack of sweating
_____ Weight loss
_____ Weight gain
_____ Aversion to heat
_____ Aversion to cold

Head & Neck

_____ Blurred vision
_____ Heaviness in the head
_____ Headache
_____ Phlegm in throat

Head and Neck cont'd

_____ Cataract
_____ Double vision
_____ Earache
_____ Ear discharge
_____ Eye pain/strain
_____ Corrected vision
_____ Nasal obstruction
_____ Nasal discharge
_____ Loss of sense of smell
_____ Hearing loss
_____ Hoarseness
_____ Nosebleeds
_____ Recurrent sore throat
_____ Red/inflamed eye
_____ Ringing in ears
_____ Sinus problems
_____ Sore on lips
_____ Sores on tongue
_____ Taste change
_____ Teeth problems
_____ Vision - see halos

Respiratory

_____ Asthma
_____ Hay fever
_____ Persistent cough
_____ Coughing blood
_____ Shortness of breath
_____ Recurrent bronchitis
_____ Phlegm production
_____ Difficulty inhaling
_____ Difficulty exhaling

Cardiovascular

_____ Chest pain
_____ High blood pressure
_____ Low blood pressure
_____ Irregular heart beat
_____ Poor circulation
_____ Swelling of ankles
_____ Varicose veins
_____ Hypochondriac pain
_____ Distention in chest or hypochondrium

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Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

Diet & Lifestyle

- Vegetarian
- Healthy diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Use drugs
- Eat a lot of sweets
- Take melatonin
- Take steroids
- Exercise regularly

Weight

- Underweight
- Normal for height
- Overweight
- Very overweight

Genitourinary

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning on urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

Musculosketal Pain

Weakness or numbness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Broken bones

Skin

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin

Skin cont'd

- Lumps underarm
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry brittle hair
- Hair falling out

Neurological

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures
- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

Emotional

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions

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Women Only

- [ ] Abnormal pap smear
- [ ] Bleed between periods
- [ ] Irregular periods
- [ ] Heavy periods
- [ ] <25 day cycle (less)
- [ ] >25 day cycle (greater)
- [ ] Endometriosis
- [ ] Painful periods
- [ ] Premenstrual tension
- [ ] Breast lumps
- [ ] Contraceptives
- [ ] Sore on genitalia
- [ ] Low sexual energy
- [ ] Vaginal discharges
- [ ] Menopausal
- [ ] Uterine prolapse
- [ ] Facial Hair
- [ ] Loss of body hair
- [ ] May be pregnant

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For Women: Why Can't I Get Pregnant? A Questionnaire of Discovery

Name _____

Natures differ,
And needs with them,
Hence the wise men of old
Did not lay down
One measure for all.
- Chuang Tse, 4th century B.C.

Diagnosis

KIDNEY DEFICIENCY/ YIN (Ki Yin-)

	Yes	No
Do you have lower back weakness, soreness or pain, or knee problems?	( )	( )
Do you have ringing in your ears or dizziness?	( )	( )
Is your hair prematurely gray?	( )	( )
Do you have vaginal dryness?	( )	( )
Is your mid-cycle fertile cervical mucus scanty or missing?	( )	( )
Do you urinate frequently?	( )	( )
Do you have dark circles around or under your eyes?	( )	( )
Do you have night sweats?	( )	( )
Are you prone to hot flashes?	( )	( )
Would you describe yourself as afraid a lot?	( )	( )

KIDNEY DEFICIENCY/ YANG (Ki Yang-)

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

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SPLEEN DEFICIENCY (Sp-)

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

BLOOD DEFICIENCY (Bl-)

(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?	( )	( )

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BLOOD DEFICIENCY (Bl-) *Continued*

	Yes	No
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?	( )	( )

BLOOD STASIS (Bl X)

(Often associated with blood deficiency symptoms)

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

LIVER QI STAGNATION (Lv Qi X)

Are you prone to emotional depression?	( )	( )
Are you prone to anger and/or rage?	( )	( )
Do you become irritable premenstrually?	( )	( )
Do you feel irritable around ovulation?	( )	( )
Does it feel like your ovulation lasts longer than it should?	( )	( )
Are your breasts sensitive/sore at ovulation?	( )	( )
Do you experience nipple pain or discharge from your nipples?	( )	( )

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LIVER QI STAGNATION (Lv Qi X) *Continued*

	Yes	No
Do you have a lot of premenstrual breast distention or pain?	( )	( )
Have you been diagnosed with elevated prolactin levels?	( )	( )
Do you become bloated premenstrually?	( )	( )
Are your pupils usually dilated and large?	( )	( )
Do you have difficulty falling asleep at night?	( )	( )
Do you experience heartburn or wake up with a bitter taste in your mouth?	( )	( )
Are your menses painful?	( )	( )
Do you feel your menstrual cramps in the external genitalia?	( )	( )
Is the menstrual blood thick and dark or purplish in color?	( )	( )

HEART DEFICIENCY (Ht-)

(Often associated with heat signs)

Do you wake up early in the morning and can't get back to sleep?	( )	( )
Do you get heart palpitations, especially when anxious?	( )	( )
Do you have nightmares?	( )	( )
Do you seem low in spirit or lacking in vitality?	( )	( )
Are you prone to agitation or extreme restlessness?	( )	( )
Do you fidget?	( )	( )
Is the tip of your tongue red?	( )	( )

EXCESS HEAT (^H)

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

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DAMPNESS (D)

(Includes Phlegm – condensed dampness)

	Yes	No
Do you feel tired and sluggish after a meal?	( )	( )
Do you have fibrocystic breasts?	( )	( )
Do you have cystic or pustular acne?	( )	( )
Do you have urgent, bright, or foul smelling stools?	( )	( )
Does your menstrual blood contain stringy tissue or mucus?	( )	( )
Are you prone to yeast infections and vaginal itching?	( )	( )
Do your joints ache, especially with movement?	( )	( )
Are you overweight?	( )	( )

DAMP HEAT (DH)

Do you have signs of heat and/or dampness as indicated earlier?	( )	( )
Do you have foul smelling, yellow or greenish vaginal discharge?	( )	( )
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?	( )	( )

COLD UTERUS (CW)

Do you fit the Kidney Yang deficiency category?	( )	( )
Do you fall into the Blood Stasis pattern?	( )	( )
Does your lower abdomen feel cooler to the touch than the rest of your body?	( )	( )