**TELL ME ABOUT YOU**

In Traditional Chinese Medicine, we look at the whole body to determine how to best help someone. To answer these questions, **type below between sections** (this should open as a word document and allow you to type), or if handwriting and more space is needed on a separate piece of paper, write as thoughtfully but concisely as you can regarding the last year or so, and bring the answers to your appointment. If the last year is significantly different than previous years, stay current so that our work can be the most useful to your current condition. State what is the usual and most common for you rather than random occurrences.

ENERGY

On a scale of 1-10, 10 being the most energetic you can imagine, where does your energy lie most days? What makes you feel more energetic or less?

SLEEP

How do you sleep in general? What time do you go to bed? How long does it take to fall asleep? Do you wake in the night? If so, at what times? Can you go back to sleep easily? If not, how long does it take? Do you dream? Do you dream excessively vivid or scary dreams? Do you awake feeling refreshed? Do you nap?

APPETITE

In general, how is your appetite? Are you averse to or do you crave certain kinds of food?

THIRST

Do you run thirsty? Is it difficult to drink enough water? Does it make you feel full or bloated easily? How much do you drink daily? Do you prefer cold, warm or room temperature water?

DIGESTION

On a regular or frequent basis, do you experience bloating, gas, nausea, heartburn, flatulence, burping? If so, in relation to what sort of foods or activity?

BM

Do you have BMs daily? If not, how often? Are they usually formed, loose or hard? Is it difficult to move them? Does it feel complete or incomplete most of the time?

URINATION

Is your urination regular, infrequent or frequent? Is it copious or very small amounts? What color is your urine? Does it have an odor most times? Do you have to wake to urinate most nights, and if so, how many times?

DIET

What is your general dietary philosophy? Do you have any dietary restrictions, and if so, why? What times of the day do you usually eat, and how many meals?

EXERCISE
What kind of movement do you do in a week? Do you have a usual exercise/movement philosophy? Do you practice movement outside of daily living on a regular basis? If so, what?

DRYNESS

Do you tend to run excessively dry, such as hair, skin, eyes, mouth?

SWEAT

Do you sweat too easily even without effort? Is it hard for your body to sweat even if exercising?

Do you sweat often overnight? If so, hot or cold sweats? Most nights or rarely?

TEMPERATURE

Do you tend to run hot, cold or average to the external environment? Does this change at certain times of the day?

MOOD

Describe your general mood/personality tendencies. If you are seeking help for depression, anxiety or other mood imbalances, we will discuss this more fully, so just be concise here. State how you would usually describe yourself. Ex: happy/positive, irritable, wound up tight/rigid, sad, depressed, anxious, easygoing, etc.

LIBIDO

How would you rate your libido: excessive, average, low? How often do you desire sexual intimacy? Do you have any difficulties with performance?

MEDICATIONS & SUPPLEMENTS

Please list all medications, supplements and dosages you take on a regular basis

MENSES LMP (first day of last menses):

How many days apart are your cycles? How long does flow last? Is flow heavy, very heavy, light, very light or medium? Do you use pads, tampons or cup? Do you have clots, large or small? What color is the blood (bright red, dark red, purple, black, brown…)? Do you have spotting before or after the main flow? If so, what color? Do you have significant cramping or other pain associated with your cycle? What mood changes do you have in relation to the cycle, before during or after? Any other symptoms directly coinciding with any part of your cycle that happens on a regular and recurring basis?