Name:	**Gender:**	**Birthday:**
Height (cm):	**Weight (kg):**	**Occupation**

1. Are you afraid of cold, hot or fear the wind?

2. Do you have spontaneous sweating or night sweats?

3. Do you have frequent headaches and dizziness?
   Have a significant pain point?

4. Is your urine clear & long, short with strong colour or normal?
   Is the stool soft, hard or normal?

5. Do you like to eat hot food or a cold food?
   Anorexia or hunger?
   Your food consumption is large, small or normal?
   Drink more or less or normal?
   Do you often feel fullness, bloating, retching, and vomiting?
   Do you have acid reflux?

6. Do you often have chest pain, chest tightness?
   Both sides of ribs often have pain?

7. Do you have tinnitus or loss of hearing?

8. Do you feel dry mouth and thirsty?
   Have bitter taste?

9. Are you often upset and worried?
   Are you often irritable, irritated, depressed, crying, and anxious?
   Full of energy or tired?

10. Often insomnia or sleepiness?
    Often have dreams and easy to wake up?

11. Your hands and feet often feel hot, cold or normal?

12. How many times does the pulse beat every minute?
    Feeling strong or weak when you touch?

13. Your joint is painful? Specific parts?

14. Female questions:
    menstruation in advance, late or normal?
    Heavy, normal or very light?
    Fresh or dark colour?

15. What are the current oral medications or injections and effects thereof?

16. Self-describe your medical history and current symptoms?

Please send 3 Photos:

1. Your tongue. Please attach 2 tongue photos, taken under the natural light, front and back side:

2. Your face colour. Please attach your face photo, taken under the natural light.: