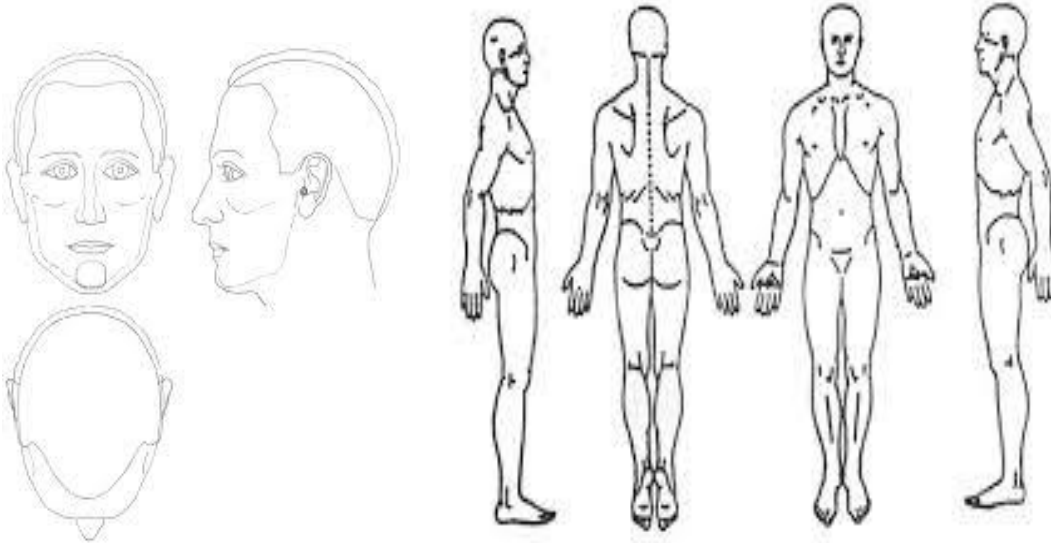


Name: \_\_\_\_\_

Date: \_\_\_\_\_

Mark on the body chart where you are feeling any pain or discomfort:



LEVEL OF PAIN FOR THE FOLLOWING (0-10): 0= No problem thru 10= Worst

Over all Pain/Numbness:	0	1	2	3	4	5	6	7	8	9	10
Headache:	0	1	2	3	4	5	6	7	8	9	10
Sleep trouble:	0	1	2	3	4	5	6	7	8	9	10
Thirst:	0	1	2	3	4	5	6	7	8	9	10
Digestion:	0	1	2	3	4	5	6	7	8	9	10
Energy:	0	1	2	3	4	5	6	7	8	9	10
Mood:	0	1	2	3	4	5	6	7	8	9	10
Urination:	0	1	2	3	4	5	6	7	8	9	10
Sweat:	0	1	2	3	4	5	6	7	8	9	10
Bowels:	0	1	2	3	4	5	6	7	8	9	10

---

**Doctor's Use Only**

**Tongue:**

Color:

Shape:

Coat:

Quiver:

**Pulses:**

**RT:**

Cun

Guan

Chi

**LT:**

Cun

Guan

Chi

Overall: