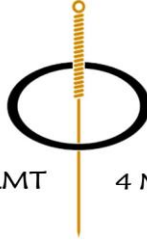


The Golden Needle Wellness



Ching Liu, MTOM, LMT

4 Mills Rd #140, Newcastle, ME 04553
GoldenNeedleWellness@gmail.com
207.808.0548

Dear New Patient,

Welcome! Thank you for your interest in Chinese medicine. Your decision to entrust the care of your health to me is a great honor, and I am truly grateful for that honor. I want you to know that I will always endeavor to provide you with the highest quality care. I also want you to know that my goal as your health care practitioner is not to heal you. My goal is to empower you to heal yourself.

True health is not just about making a problem go away, but is, instead about removing the possibility of the problem ever occurring again. This requires working with you as a whole person, not just the parts that aren't working properly. It is a much greater challenge, but it also reaps much greater rewards. To this end, I have sent you some forms that I'd like you to fill out and bring with you to your first appointment. I assure you that all information you provide on these forms will be kept strictly confidential, and will never be shared without your explicit written permission. If you have any questions, please feel free to call me at (207) 808-0548, and I will be happy to answer them.

Again, welcome to my clinic. You have taken an important step on your journey to vibrant health. It is my privilege to walk alongside you.

Be well,

A handwritten signature in black ink, appearing to read 'Ching Liu'.

Ching Liu, MTOM, LMT

Our Clinic Protects Your Health Information and Privacy

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information.:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, worker's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

You will be able to access and correct personal information we have collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.).

I value our relationship, and respect your right to privacy. If you have questions about these privacy guidelines, please call during regular business hours at (207)808-0548.

**Consent to the Use and Disclosure of Health Information for
Treatment, Payment, or Healthcare Operations**

NAME _____ BIRTHDATE _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

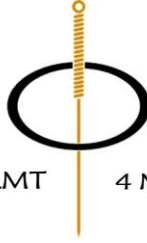
I request the following restrictions to the use of disclosure of my health information:

X _____
Patient Signature or Legal Representative Date Printed Name and Relationship

Office Use Only:

↑ Accepted _____
↑ Denied Signature Date

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PATIENT CONFIDENTIAL INFORMATION

I. Name

First Middle Last Preferred name

2. Address

Street City State Zip

3. Home Phone

4. Work Phone

5. Mobile

6. Preferred Daytime Phone

Home

Work

Mobile

7. Fax

8. Email

9. Date of Birth

10. Age

11. Gender

M

F

12. Marital:

M

S

D W

15. Occupation

16. Employer

17. Work Address

Street City State Zip

20. In case of emergency, call

Relationship

Address

Street City State Zip Phone

21. FOR MINORS Please list both parents' names and addresses:

Blank lines for listing parents' names and addresses.

I understand that the practitioner has a 24-hour cancellation policy. This means that if I cancel an appointment less than 24 hours before the scheduled time, I will be charged the standard fee.

Initials

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of my health.

DATED PATIENT'S SIGNATURE

(parent's signature if patient is minor)

How did you hear about me?

Blank line for answering how the patient heard about the office.

Patient Health History

Name: _____
 First Last Preferred Age M F Gender Date

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Note: Please do not treat this questionnaire as a chore to be completed. Instead, treat it as an opportunity to become aware of the current state of your overall health. This awareness is a crucial first step to self-healing. If you find it overwhelming, do not hesitate to take a break and come back to it when you feel ready.

1. When and where did you last receive health care? _____
For what reason? _____

2. Has your case been referred to an attorney? Y N

3. What is your **main objective** in coming here, and what are the underlying health conditions that motivate this objective?

- Please phrase your objective in the form of an active statement that describes what you want, not what you don't want. E.g. if you have back pain, then you could say, "I have come in order to have a strong, flexible, healthy back," but you would not say, "I have come to have a pain-free back", or "I have come to get rid of my back pain."
- When describing your underlying health conditions, please include how the conditions affect you, what you have done to correct them, and when they started.

Main objective: _____
Underlying health conditions: _____

4. Do you have any **secondary objectives** in coming here?

a. Objective: _____
Underlying health conditions: _____

b. Objective: _____
Underlying health conditions: _____

c. Objective: _____
Underlying health conditions: _____

d. Objective: _____
Underlying health conditions: _____

5. Please list any foods, drugs, or medications you are **hypersensitive or allergic** to (please include reaction):

6. Please list any **medications** (prescribed and over-the-counter), **vitamins, supplements, and herbs** you are currently taking:

7. Do you have any reason to believe you may be **pregnant**? Y N

If so, how far along are you? _____

8. Do you have any **infectious diseases**? Y N If yes, please identify: _____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Family history:**

	Self	Father	Mother	Brothers	Sisters	Spouse	Children
Age, or age at death	_____	_____	_____	_____	_____	_____	_____
If deceased, cause of death:	_____	_____	_____	_____	_____	_____	_____
If living, health status:	_____	_____	_____	_____	_____	_____	_____

Check if applicable: (10 = Vibrant health, 5 = Average health, 1 = Very poor health)

Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

I3. **Hospitalizations and Surgeries:**

Date:

Reason:

Operation(s) performed:

I4. Please describe your **birth**:

I5. Please describe your **childhood**:

I6. Please list any **serious and/or childhood illnesses** and their approximate dates:

Date:

Illness:

I7. Please describe any **traumatic experiences** you have had and give their approximate dates (i.e. divorce, change of residence, bankruptcy, injury, death of a loved one, etc.)

Date:

Event:

For the following questions, Please *circle* any of the following that you experience *now* and *underline* any that you have experienced in the *past*. Then write a number next to the condition representing how severe it was or is for you. 10 means extremely severe, 1 means very mild. If you don't know what the condition is, just write a question mark.

• For example, if you have experienced mild ear ringing in the past, and currently experience severe sinus problems, you would do the following:

Ear ringing 3 sinus problems 8

18. **Emotions:**

Mood Swings Anxiety Mental Tension Depression Mania

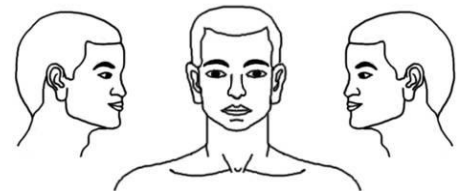
Please list one or two emotions that are influential in your life and which are either frequently experienced or difficult to express:

19. **Energy and Immunity:**

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

20. **Head, Eye, Ear, Nose, and Throat:**

Impaired Vision	Eye Pain/Strain	Headaches: please describe, and mark where you feel pain: _____
Glasses/Contacts	Tearing/Dryness	Glaucoma
Impaired Hearing	Ear Ringing	Earaches
Nose Bleeds	Hay Fever	Sinus Problems
Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems



21. **Respiratory:**

Pneumonia	Frequent Colds	Difficulty Breathing	Emphysema	
Persistent Cough	Pleurisy	Asthma	Tuberculosis	Shortness of Breath

Other Respiratory Problems: _____

22. **Cardiovascular:**

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	Palpitations/Fluttering
Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins	

23. **Gastrointestinal:**

Ulcers	Changes in Appetite	Nausea/Vomiting	Heartburn	Abdominal Pain
Passing Gas	Belching	Gall Bladder Disease	Liver Disease	Hemorrhoids

24. **Genito-Urinary Tract:**

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Frequent Urination at Night
Kidney Stones	Impaired Urination	Blood in Urine		

25. Female Reproductive/Breasts:

Breast Lumps/Tenderness Nipple Discharge Vaginal Discharge Difficulty Conceiving Menopausal Symptoms

26. Menstrual/Birthing History:

of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: _____

Age of First Menses: _____ # of Abortions: _____ Birth Control Type: _____

Date of last period: _____

Length of Cycle: _____ days If irregular, give range: _____ to _____ days

Duration of bleeding: _____ days Bleeding between cycles? Y N When? _____

Color of blood: pale red bright red dark red brown purple

Consistency of blood: watery normal thick, sticky clots

Quantity of blood: very light light normal heavy very heavy

PMS: breast distention headache bloating, edema chocolate craving

emotional What emotions? _____

other

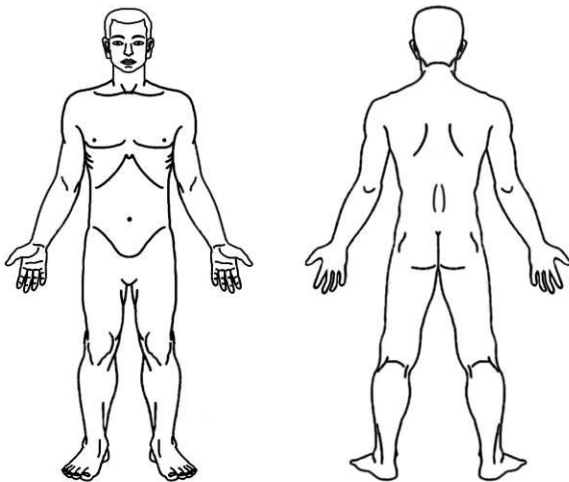
Please describe any cramping: _____

27. Male Reproductive:

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

28. Musculoskeletal:

Please mark where you feel pain with a number, and describe the pain on the corresponding lines:



1. _____
2. _____
3. _____
4. _____

29. **Neurological:**

Vertigo/Dizziness

Paralysis

Numbness/Tingling

Loss of Balance

Seizures/Epilepsy

30. **Endocrine:**

Hypothyroid

Hyperthyroid

Hypoglycemia

Feeling Hot or Cold

Night Sweats

Diabetes Type I

Diabetes Type 2

31. **Other:**

Anemia

Cancer

Rashes

Eczema/Hives

Cold Hands/Feet

Is there anything else I should know? _____

32. **Lifestyle:**

a. Do you now, or have you ever undertaken a restricted diet? Please give dates and describe:

b. Please describe a typical day's diet. This includes all meals, snacks, and beverages.

c. Times of the day you usually eat: _____

d. Typical state of mind as you eat: _____

e. Cups of water you drink each day: _____

f. Exercise routine: _____

g. Spiritual practice: _____

h. Typical bedtime: _____ Do you sleep soundly? Y N

i. Typical wake time: _____ Do you wake rested? Y N

j. Level of education completed: High School Bachelors Masters Doctorate Other _____

k. Do you have any silver amalgam fillings in your mouth? Y N

l. Current occupation: _____ Hours worked/week: _____

m. Do you enjoy this occupation? Why/why not? _____

n. Briefly describe your occupational history:

Date: _____ Occupation: _____

o. Nicotine/Alcohol/Caffeine/Recreational Drug Use: _____

p. What do you like to do in your free time? _____

For the following section, please ✓ check once for mild conditions, ✓✓ check twice for moderate conditions, and check ✓✓✓ three times for serious conditions. Some conditions appear more than once – just repeat your answer anywhere they appear.

Water	Wood	Fire
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lower back pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sores on tongue
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knee pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Migraines	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat/tonsillitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Leg weakness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fullness/pain below ribs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry scalp
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wrist & hand pain/soreness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions/rashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold arms and/or legs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulder/neck tension	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching/burning skin
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hearing loss	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions/spasms	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cysts/tumors
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in ears	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold fingers/toes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear infections
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in ears	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lymphatic swelling
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus congestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor eyesight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot hands/feet
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Edema (water retention)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry/red eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dislike of heat
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Darkness under eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Watery eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry mouth
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dislike of cold	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum problems
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hair thinning or loss	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blurry vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Premature aging	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor night vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Facial redness
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart palpitations
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney stones	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shingles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Perspire very easily	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dark urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Warts	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night sweats
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot sensation in afternoon	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty falling asleep
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma, difficult to inhale	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Alternating constipation/diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Waking very easily/often
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid weight change	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vivid dreaming
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loose teeth	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue on waking
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Reduced sexual energy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thirsty but don't like to drink
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Increased sexual energy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallstones	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thirst for cold drinks
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Insomnia 1P to 3A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent/extreme thirst
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Craving for sour taste	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Craving for bitter taste
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor memory/concentration	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PMS/painful menses	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Laughing to cover up other emotions
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bitter taste in mouth	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> "Adrenaline junkie"
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thirst for hot drinks	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irritability	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Restlessness
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Craving for salty taste	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Indecisiveness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxiety
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emotional instability	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frustration	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Manic behavior
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Often feel afraid	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Easily angered	

Earth	Metal
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heaviness in legs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bronchitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Indigestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma, difficult to exhale
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Flatulence	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shallow breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loose stools	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus congestion
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Increased appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal infections
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Decreased appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry skin
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hungry but don't want to eat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Catch colds easily/often
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweating with mild movement
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Craving for spicy taste
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach pain/ulcer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feelings of grief/sadness
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sores on lips/in mouth	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Uncontrollable weeping
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heartburn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of inspiration in life
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bad breath	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low body weight	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prolonged bleeding (when injured)	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Easy bruising	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Organ prolapse	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal infections	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sticky saliva	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thirsty but don't like to drink	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Craving for sweet taste	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Not feeling supported/nurtured	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Putting others' needs over your own	