Yo San University Clinic
Patient Personal Data Form

WELCOME TO YO SAN UNIVERSITY CLINIC

Please fill out the demographic information below

PATIENT ID NUMBER:
First Name:
Last Name:
Date of birth: **Male / Female**
Address:
City: **State:** **Zip:**
Home phone: Work/Mobile phone:
Email:
May we contact you with clinic updates and information? □ *Yes* □ *No*
Occupation:
Referred by:
Name of emergency contact:
Phone number of emergency contact:
Name of Medical doctor:
Other healthcare provider:
Other healthcare provider:

Please ask our front office staff if you have any questions on filling out these forms.

Thank you for visiting Yo San University Clinic.

Yo San University Clinic
13315 W. Washington Blvd · Los Angeles, CA 90066 · Tel: 310.577.3006 ·
www.yosan.edu

Notice of Privacy Practices
Patient Acknowledgement

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of Yo San University Clinic's Notice of Privacy Practice.

Name: _____
(*Please print)*

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ The patient was unable to sign
- ☐ Other (Please provide specific details)

_____

Name of Employee: _____ Date:_____

YO SAN UNIVERSITY CLINIC
TEACHING CLINIC & OFFICE POLICY AGREEMENT

Welcome to Yo San University Clinic.

Yo San University is a teaching Clinic. Our goal is to provide excellent health care to you and a learning environment for student interns to gain knowledge and experience of the practice of Traditional Chinese Medicine. Experienced Licensed Acupuncturists (L.Ac.) supervise our interns and oversee every treatment in the clinic. Treatment procedures may include acupuncture, electroacupuncture, moxibustion, cupping, gua-sha, acupressure, tui-na (Asian bodywork/ massage), heat, cold, breathing techniques, exercises, along with herbal prescriptions (including approved animal and mineral products), nutritional and dietary advice to promote, maintain and restore health.

A critical part of the students' clinical education is to observe experienced Interns treating patients. As such, your treatment sessions may be observed by student interns other than your attending intern(s).

Due to scheduling and other limitations, you may not be able to see the same intern for every treatment; we will try to accommodate your requests where possible.

Please be punctual for your appointment. This is a high-volume teaching clinic, unforeseen time constraints may affect your treatment time.

Patient clinical records may be reviewed and used as teaching material as needed by the clinical faculty, the Dean of Clinical Education and other senior university administrators.

As a non-profit teaching facility, we adopt the following office policies:

- We do not bill insurance directly. Patients are responsible for all fees at the time of service. Upon your request we will provide you with a completed Health Insurance Claim Form for you to submit to your insurance company
- If you need to change or cancel an appointment, please inform us 24 hours in advance the appointment. We reserve the right to charge a fee for no-show / late cancelations in the amount of the treatment missed
- There is a $35.00 service charge for returned checks
- Herbal products are not returnable or refundable
- For patients 18 or younger, a parent/caregiver must be present during treatment. The parent/caregiver must sign the "Treating a Minor" consent form.

I have read and agree to the above terms.

Print name: _____

Signature: _____ Date: _____

YO SAN UNIVERSITY CLINIC PAYMENT POLICIES

Welcome to Yo San University Clinic.

We have a number of specialties and services to serve your healthcare needs. In order to provide you, our customer, with the best possible service you will need to understand our payment policy.

Payment is due at the time of service.

We currently do not directly bill insurance companies for our services. You are responsible for all fees at the time of service. As a courtesy to you, we will, upon your request, provide you with a completed Health Insurance Claim Form for you to submit to your insurance company

You will be assessed a "no show/late cancellation" fee for a missed appointment as well as for cancellations made with less than 24 hours notice. The fee charged will be:

For Licensed Practitioner appointments: $50

For Intern/Healthy Aging appointments: $25

For Women's Health/Orthopedics & Pain appointments: $35

Payment is required for all herbal prescriptions/refills at the time of service.

Delinquent accounts will be referred to a professional agency for collection.

Should you need to make other payment arrangements, or have questions regarding your bill please contact the Clinic Manager at (310) 577-3006, or via email at clinicmanager@yosan.edu.

For your convenience, the Clinic accepts cash, checks, VISA and MasterCard.

I have read and agree to the above terms.

Print name: _____

Signature: _____ Date: _____

YO SAN UNIVERSITY CLINIC

Please take a few moments to help us get to know you, so that we can better develop services for your health care needs. This form will be kept separately from your patient file and your answers to these questions will be anonymous.

Today's date is: _____

Home address zip code: _____

How did you hear about Yo San University Clinic?

( ) Free lecture

( ) Health Fair Name of Health Fair: _____

( ) Magazine: Name of magazine: _____

( ) Newspaper: Name of newspaper:_____

( ) Referral: Name of referrer:_____

( ) Yo San University Open House event

( ) Yo San University website

( ) Other: Please indicate:_____

I am: ( ) Female ( ) Male

My age range is:
( ) under 18 ( ) 18-25 ( ) 26-40 ( ) 41-55 ( ) 55-65 ( ) over 65

My annual household income is approximately:
( ) under $20,000 ( ) $20,001 - $30,000 ( ) $30,001 - $45,000
( ) $45,001 - $60,000 ( ) $60,001 - $75,000 ( ) over $75,000
( ) Prefer not to answer

The race/ethnicity that I most identify with is:
( ) American Indian or Alaskan Native ( ) Asian
( ) Black / African American ( ) Hispanic
( ) Native Hawaiian/Other Pacific Islander ( ) Multi-racial / ethnicity
( ) Race/ Ethnicity Unknown ( ) Other
( ) Prefer not to answer

YO SAN UNIVERSITY
OF TRADITIONAL CHINESE MEDICINE

Yo San Fertility Clinic
13315 W. Washington Blvd. Los Angeles, CA 90066
Tel: 310.577.3006 www.yosan.edu

Name (Last, First, Middle)	Date

Age at which menses began _____

Are your periods painful? ☐Yes ☐No

How many days do you normally bleed? _____

How heavy is the bleeding? ☐Light ☐Normal ☐Heavy

What color is the blood? ☐Light red ☐Red ☐Dark red

☐Purple ☐Brown ☐Black

Is there clotting? ☐Yes ☐No

Does your face break out before or during your period? ☐Yes ☐No

Do your breasts become tender premenstrually? ☐Yes ☐No

Do you bleed or spot between periods? ☐Yes ☐No

Are your menstrual cycles spaced irregularly? ☐Yes ☐No

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

Date of last menstrual period _____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D & C been performed?	_____	_____

Have you ever had an abnormal pap smear? ☐Yes ☐No

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐Yes ☐No

Have you ever had a venereal disease? ☐Yes ☐No

Do you get yeast infections regularly? ☐Yes ☐No

Have you ever had pelvic inflammatory disease? ☐Yes ☐No

Were you treated for it? ☐Yes ☐No

How? _____

Date of last pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps?

☐Yes ☐No

Have you ever been diagnosed with endometriosis? ☐Yes ☐No

Have you been diagnosed with pelvic adhesions? ☐Yes ☐No

Have you been diagnosed with any pelvic abnormalities? ☐Yes ☐No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? ☐Yes ☐No

How? _____

Do you ovulate on your own? ☐Yes ☐No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? ☐Yes ☐No

Yo San University's Fertility Clinic
Health History

NAME (Last, First, Middle)	DATE

Please check any symptoms you currently have or have had in the last 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
- ☐ 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 eyes
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Sores on lips
- ☐ Taste change
- ☐ Teeth problems
- ☐ Vision disturbances

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

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

Diet/Lifestyle
- ☐ Vegetarian
- ☐ Healthy diet
- ☐ Eat much fried food
- ☐ Eat much meat
- ☐ Smoke cigarette
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Recreational drug use
- ☐ Eat too many sweets
- ☐ Take Melatonin
- ☐ Take steroids
- ☐ Exercise regularly
- ☐ Exercise excessively

Weight
- ☐ underweight
- ☐ normal for height
- ☐ overweight
- ☐ very overweight

Genitourinary
- ☐ Pale urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urination
- ☐ Profuse urine
- ☐ Frequent urination
- ☐ Poor bladder control
- ☐ Urgency to urinate

Musculoskeletal

Pain/weakness/numbness in:
- ☐ Arms
- ☐ Hands
- ☐ Legs
- ☐ Feet
- ☐ Joints
- ☐ Knees
- ☐ Hips
- ☐ Shoulders
- ☐ Upper back
- ☐ Lower back
- ☐ Pain all over
- ☐ Weakness all over
- ☐ Lack of strength
- ☐ Cold limbs
- ☐ Broken bones

Skin
- ☐ Thick skin
- ☐ Thin skin
- ☐ Broken blood vessels
- ☐ Poor clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Dark circles under eyes
- ☐ Bags under eyes
- ☐ Swollen lymph glands
- ☐ Dry skin
- ☐ Acne
- ☐ Brittle nails
- ☐ Premature gray hair
- ☐ Dry, brittle hair
- ☐ Hair loss

Neurologic
- ☐ Fainting
- ☐ Convulsions
- ☐ Handwriting change
- ☐ Paralysis
- ☐ Stroke
- ☐ Seizures
- ☐ Tremors
- ☐ Recent clumsiness
- ☐ Drowsiness
- ☐ Vertigo
- ☐ Poor balance

Emotional
- ☐ Insomnia
- ☐ Irritability
- ☐ Often angry
- ☐ Troubling dreams
- ☐ Cry uncontrollably
- ☐ Feel sadness often
- ☐ Forgetful
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Fearful
- ☐ Unrestrained joy
- ☐ Night terrors
- ☐ Difficulty expressing emotions

Have you ever been diagnosed with a chlamydial infection? ☐Yes ☐No

Do you have chronic vaginal discharge? ☐Yes ☐No

Do you have any sores on your genitalia? ☐Yes ☐No

Have you had fertility treatments? ☐Yes ☐No

If yes, when and where?_____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? ☐Yes ☐No

When? _____ How long? _____

Have your fallopian tubes been evaluated medically? ☐Yes ☐No

What were the results? _____

Have you had any tubal operations? ☐Yes ☐No

Have you had any hormone laboratory tests performed? ☐Yes ☐No

What were the results? _____

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

☐Yes ☐No

How long have you been married or living together? _____

Has he had a fertility workup? ☐Yes ☐No

What were the results? _____

Is your partner supportive of your wish to conceive? ☐Yes ☐No

Have you taken oral contraceptives? ☐Yes ☐No

When? _____ How long? _____

Have you ever had an IUD? ☐Yes ☐No

When? _____ How long? _____

Have you ever taken DepoProvera? ☐Yes ☐No

When? _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ☐Yes ☐No

What was it? _____

Do you get premenstrual low back pain? ☐Yes ☐No

Do your bowel movements become loose at the beginning of your

period? ☐Yes ☐No

How is your sexual energy? ☐Low ☐Normal ☐High

Do you douche regularly? ☐Yes ☐No

With what? _____

Do you use vaginal lubricants? ☐Yes ☐No

Are you more than 20% over your ideal body weight? ☐Yes ☐No

Are you more than 20% below your ideal body weight? ☐Yes ☐No

Do you have a stressful occupation? ☐Yes ☐No

Do you exercise regularly? ☐Yes ☐No

Do you have excessive facial hair? ☐Yes ☐No

Do you have excessively oily skin? ☐Yes ☐No

Have you experienced excessive loss of head hair? ☐Yes ☐No

Have you noticed discharge from your nipples? ☐Yes ☐No

Was your mother exposed to diethylstilbestrol (DES) when she was

pregnant with you? ☐Yes ☐No

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

☐Yes ☐No

Are you presently taking steroids? ☐Yes ☐No

Answer YES or NO to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third YES responses in any diagnostic category, then you may have an element of this imbalance in your system. You may have more than one kind of imbalance operating at the same time, so don't be surprised if you have 50 percent YES answers for more than one diagnostic category.

DIAGNOSIS

KIDNEY YIN DEFICIENCY

Do you have lower back weakness, soreness, or pain, or knee problems?	☐Yes	☐No
Do you have ringing in your ears or dizziness?	☐Yes	☐No
Does your hair prematurely gray?	☐Yes	☐No
Do you have vaginal dryness?	☐Yes	☐No
Is your midcycle fertile cervical mucus scanty or missing?	☐Yes	☐No
Do you have dark circles around or under your eyes?	☐Yes	☐No
Do you have night sweats?	☐Yes	☐No
Are you prone to hot flashes?	☐Yes	☐No
Would you describe yourself as afraid a lot?	☐Yes	☐No
Does your tongue lack coating? Does it appear shiny or peeled?	☐Yes	☐No

DIAGNOSIS

KIDNEY YANG DEFICIENCY

Do you have lower back premenstrually?	☐Yes	☐No
Is your low back sore or weak?	☐Yes	☐No
Are your feet cold, especially at night?	☐Yes	☐No
Are you typically colder than those around you?	☐Yes	☐No
Is your libido low?	☐Yes	☐No
Are you often fearful?	☐Yes	☐No
Do you wake up at night or early in the morning because you have to urinate?	☐Yes	☐No
Do you urinate frequently, and is the urine diluted and/or profuse?	☐Yes	☐No
Do you have early morning loose, urgent stools?	☐Yes	☐No
Do you have profuse vaginal discharge?	☐Yes	☐No
Does your menstrual blood tend to be dull in color?	☐Yes	☐No
Do you feel cold cramps during your period that respond to a heating pad?	☐Yes	☐No
Is your tongue pale, moist, and swollen?	☐Yes	☐No

DIAGNOSIS

SPLEEN QI DEFICIENCY

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

Does your tongue look swollen, with teeth marks on the sides? ☐Yes ☐No

Do you have a pale, yellowish complexion? ☐Yes ☐No

DIAGNOSIS

BLOOD DEFICIENCY (*not necessarily equated with anemia*)

Are your menses scanty and/or late? ☐Yes ☐No

Do you have dry, flaky skin? ☐Yes ☐No

Are you prone to getting chapped lips? ☐Yes ☐No

Are your fingernails or toenails brittle? ☐Yes ☐No

Are you losing hair on your head (not in patches, but all over)? ☐Yes ☐No

Is your hair brittle or dry? ☐Yes ☐No

Do you have diminished nighttime vision? ☐Yes ☐No

Do you get dizzy or light-headed around your period? ☐Yes ☐No

Are your lips, the inner side of your lower eyelids, or tongue pale in color? ☐Yes ☐No

DIAGNOSIS

BLOOD STASIS (*often associated with blood deficiency symptoms*)

Is your menstrual flow ever brown or black in color? ☐Yes ☐No

Do you feel midcycle pain around your ovaries? ☐Yes ☐No

Do you have painful, unmovable breast lumps? ☐Yes ☐No

Do you experience periodic numbness of your hands and feet (especially at night)? ☐Yes ☐No

Do you have varicose or spider veins? ☐Yes ☐No

Do you have red hemangiomas (cherry red spots) on your skin? ☐Yes ☐No

Does your complexion appear dark and “sooty”? ☐Yes ☐No

Do you have chronic hemorrhoids? ☐Yes ☐No

Does your menstrual blood contain clots? ☐Yes ☐No

Have you been diagnosed with endometriosis or uterine fibroids? ☐Yes ☐No

Is your lower abdomen tender to palpation (resisting touch)? ☐Yes ☐No

Can you feel any abnormal lumps in your lower abdomen? ☐Yes ☐No

Do you have piercing or stabbing menstrual cramps? ☐Yes ☐No

Does your tongue look dark? ☐Yes ☐No

Do you have dark spots on your tongue? ☐Yes ☐No

Are the veins beneath your tongue twisty and tortuous? ☐Yes ☐No

Do you have dark spots in your eyes? ☐Yes ☐No

Have you been diagnosed with any vascular abnormality or blood clotting disorder? ☐Yes ☐No

DIAGNOSIS

LIVER QI STAGNATION

Are you prone to emotional depression? ☐Yes ☐No

Are you prone to anger and/or rage? ☐Yes ☐No

Do you become irritable premenstrually? ☐Yes ☐No

Do you feel bloated or irritable around ovulation? ☐Yes ☐No

Does it feel as if your ovulation lasts longer than it should? ☐Yes ☐No

Are your breasts sensitive/sore at ovulation? ☐Yes ☐No

Do you experience nipple pain or discharge from your nipples? ☐Yes ☐No

Do you have a lot of premenstrual breast distension or pain? ☐Yes ☐No

Have you been diagnosed with elevated prolactin levels? ☐Yes ☐No

Do you become bloated premenstrually? ☐Yes ☐No

Are your pupils usually dilated and large? ☐Yes ☐No

Do you have difficulty falling asleep at night? ☐Yes ☐No

Do you experience heartburn or wake up with a bitter taste in your mouth? ☐Yes ☐No

Are your menses painful? ☐Yes ☐No

Do you feel your menstrual cramps in the external genital area? ☐Yes ☐No

Is your menstrual blood thick and dark, or purplish in color? ☐Yes ☐No

Is your tongue dark or purplish in color? ☐Yes ☐No

DIAGNOSIS

HEART DEFICIENCY (*often associated with heat*)

Do you wake up early in the morning and have trouble getting back to sleep? ☐Yes ☐No

Do you have heart palpitations, especially when anxious? ☐Yes ☐No

Do you have nightmares? ☐Yes ☐No

Do you seem low in spirit or lacking in vitality? ☐Yes ☐No

Are you prone to agitation or extreme restlessness? ☐Yes ☐No

Do you fidget? ☐Yes ☐No

Is the tip of your tongue red? ☐Yes ☐No

Is there a crack in the center of your tongue that extends to the tip? ☐Yes ☐No

Do you sweat excessively, especially on your chest? ☐Yes ☐No

DIAGNOSIS

EXCESS HEAT

Is your pulse rate rapid? ☐Yes ☐No

Is your mouth and throat usually dry? ☐Yes ☐No

Are you thirsty for cold drinks most of the time? ☐Yes ☐No

Do you often feel warmer than those around you? ☐Yes ☐No

Do you wake up sweating or have hot flashes? ☐Yes ☐No

Do you break out with red acne (especially premenstrually)? ☐Yes ☐No

Do you have a short menstrual cycle? ☐Yes ☐No

Do you have vaginal irritation or rashes? ☐Yes ☐No

DIAGNOSIS

DAMPNESS

Do you feel tired and sluggish after a meal? ☐Yes ☐No

Do you have fibrocystic breasts? ☐Yes ☐No

Do you have cystic or pustular acne? ☐Yes ☐No

Do you have urgent, bright, or foul-smelling stools? ☐Yes ☐No

Does your menstrual blood contain stringy tissue or mucus? ☐Yes ☐No

Are you prone to yeast infections and vaginal itching? ☐Yes ☐No

Do your joints ache, especially with movement? ☐Yes ☐No

Are you overweight? ☐Yes ☐No

Do you have a wet, slimy tongue? ☐Yes ☐No

DIAGNOSIS

DAMP HEAT

Do you have signs of heat and/or dampness as indicated above? ☐Yes ☐No

Do you have foul-smelling, yellow, or greenish vaginal discharge? ☐Yes ☐No

Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? ☐Yes ☐No

DIAGNOSIS

COLD UTERUS

Do you fit the Kidney Yang deficiency category?	☐Yes	☐No
Do you fall into the Blood stasis pattern?	☐Yes	☐No
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	☐Yes	☐No