Online Consultation Form

Name: **Gender:** **Date of Birth:** **Tel:**

Health fund name & number: **Address:**

Please answer the following questions as detail as possible:

1. Chief complaint: any discomfort and how long, any symptoms along with the chief complaint? ----

2. Any pain or discomfort?
(1) What kind of pain or discomfort? (including pain, nausea, palpation, short of breath,etc) ----
(2) How severe? Rate out of 10, 1 is less pain, 10 is the most pain. If tinnitus, high frequency or low frequency? ----
(3) When and How it started? ----
(4) What cause it? ----
(5) What make it better or worse? ----
(6) Any symptom accompany with it? ----
(7) What time happen during a day? Or when is the most severe? ----
(8) How was the treatment? See any doctor or specialist? What the diagnosis? ----

3.Body feels cold or hot?
(1) Usually the body feeling cold or hot ----
(2) When feels cold or hot during a day? ----
(3) Which body part feels cold or hot? ----
(4) Usually like to drink cold water or warm water? ----
(5) Easy feels thirsty, dry mouth ----
(6) Easy got mouth ulcer or tongue pain ----

4.Any abnormal sweating?
(1) When during a day? ----
(2) Which part of body? ----

5.How is sleep?
(1) Is hard to fall in asleep ? ----
(2) Easy to wake up? Easy to back asleep after wake up? How about dreams? ----

6.How is the appetite?
(1) Appetite is good or not, if carving for some food? ----
(2) Any Discomfort after eating? What kind of discomfort? when it starts? And last how long time？ ----

7.Stress level?
(1) How much out of the 10? (0 is no stress, 10 is most stress) ----
(2) How is the mood? (10 is very good) ----

8.Energy level?
(1) How much out of the 10? (0 is no energy, 10 is most energize) ----
(2) Easy feels heavy body? When? ----

9.Bowel motion
(1) How many times per day? Usually when? ----

(2) Normal formed stools, hard dry stools? or loose stool? ----
(3) Any discomfort accompany with bowel motion? ----

10.Urination
(1) How frequent during day? ----
(2) How frequent after asleep? ----
(3) Clear or yellow urine ? ----
(4) Any discomfort accompany with urination? ----

11.Female Patient
(1) Today is which day of the Cycle? (when was the menopause). ----
(2) The cycle is regular or not, how earlier or later? ----
(3) Any discomfort accompany, before or during? ----
(4) How many days last? ----
(5) The period is light, red, dark color? any clots? ----
(6) How many times of pregnancy? How old the youngest kid? Natural delivery or cesarean? ----

12. History:
Please list the disease name you are currently have, how long time if you have the disease? ----
Please list any abnormal exam result and when the exam ----
Please list the medicine you are currently taking ----

13. Tongue picture
Please take two pictures like the following
Please under the proper light, try to open the mouth, and including the face around the mouth.