

Medicated Diet Seminar
November 6th 2011
Body Constitution Questionnaire

<u>Yang Deficiency Type</u>	<u>Yin Deficiency Type</u>
1. Do you have cold hands and feet? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Do you have feverish sensation in body and on face? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you feel cold in the epigastrium, back, waist or knee area? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Do you sweat easily in your palms? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you wear more clothes than others? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you have dry lips and skin? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you like summer and dislike winter? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Are you intolerant to summer and tolerant to winter? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you more vulnerable to common cold or the flu than others? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Do you have constipation or dry stools? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Will you have diarrhea after eating cold food? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Do you dry eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Will you have any discomfort after your lower abdomen exposed to wind? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Do you have dry mouth and throat, and always want to drink water? <input type="checkbox"/> Yes <input type="checkbox"/> No
Total:	Total:

<u>Qi Deficiency Type</u>	<u>Phlegm-Damp Type</u>
1. Do you get tired easily? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Do you have chest oppression and abdominal fullness? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you easily get shortness of breath or palpitation? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Do you have a heaviness sensation in your body or limbs? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you often have dizziness or vertigo? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you have a chubby and mushy abdomen? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you more vulnerable to common cold or the flu than others? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you have an oily face? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you prefer quiet and dislike speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Do you have puffy eyelids? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have a low and weak voice? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Do you have a sticky sensation or sweet taste in mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you sweat easily even with very little exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Do you usually have lots of sputum? <input type="checkbox"/> Yes <input type="checkbox"/> No
Total:	Total:

<u>Damp-Heat Type</u>	<u>Qi Stagnation Type</u>
1. Are your face and nose greasy and shiny? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Are you always in low spirits and irritated? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you more susceptible to acne, sores or ulcer? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Are you susceptible to emotional stress and anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you often have a bitter taste in mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Are you sentimental and emotionally vulnerable? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does your skin get itchy easily? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you easily get scared or frightened? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have tenesmus (urgent, painful) with sticky and foul stool? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Do you have hypochondriac pain or distending pain in the breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have urgent urination with burning sensation and scanty, reddish urine? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Do you sigh frequently without reason? <input type="checkbox"/> Yes <input type="checkbox"/> No
	7. Do you have a sensation of a foreign body in the throat? <input type="checkbox"/> Yes <input type="checkbox"/> No
Total:	Total:

<u>Blood Stasis Type</u>	<u>Endowment (Allergy) Type</u>
1. Are you susceptible to ecchymosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Do you sneeze even you don't have common cold or flu? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have very tiny blood vessels appear on the cheek bone area? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Do you have nose congestion or running nose even you don't have common cold or flu? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have any sharp pain in your body? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you cough or pant during change of seasons or when exposed to peculiar smell such as paint or gas? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have a dark complexion with pigmentation? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Are you allergic to certain food, drugs or pollen? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you easily get dark eye circles? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Do you get urticaria (hive) easily? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you forgetful? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Do you ever have purpura due to allergic reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are your lips dark or purplish? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Does your skin get obvious red marks after scratch lightly? <input type="checkbox"/> Yes <input type="checkbox"/> No
Total:	Total:

Total for Yang Def. Type:		Total for Yin Def. Type	
Total for Qi Def. Type		Total for Phlegm-Damp Type	
Total for Damp-Heat Type		Total for Qi Stagnation Type	
Total for Blood Stasis Type		Total for Endowment (Allergy) Type	