

IMPORTANT

This questionnaire is not a substitute for a face-to-face consultation. If you have concerns about your health you should consult a qualified medical practitioner. This questionnaire is based on the Traditional Chinese approach to health and well-being.

Please complete as many of the applicable sections as you can and return to:

Anthony Horrocks
Three Treasures Health
60 Fore Street
North Petherton
Nr Bridgwater,
Somerset TA6 6QA
[Email: tony@threetreasureshealth.com](mailto:tony@threetreasureshealth.com)
[Website: www.threetreasureshealth.com](http://www.threetreasureshealth.com)

DIAGNOSTIC QUESTIONNAIRE

CONFIDENTIAL *The information that you provide will not be divulged to any third party without your express permission*

Please answer as many questions as possible to enable an accurate diagnosis to be made.

Date Questionnaire completed ___/___/___

Your name _____ Address _____

Post Code _____ Telephone Number _____ Date of Birth ___/___/___

Email address: _____ website: _____

Name and address of your Doctor (will not be contacted without your permission):

Tongue: Please examine your tongue in a mirror and underline the descriptions that you think apply:

SHAPE: Normal/thin/swollen/long /short/stiff/
SPOTS: Small/large/red/white/none
COLOUR: Normal/red/pink/blue-purple/red-purple
CRACKS: No cracks, some cracks, many cracks
COATING: thick/thin/white/yellow/brown/black/
MOISTURE: normal/moist/wet/dry
MOVEMENT: normal/quiver/moves

**Self Description - Main
health problem/s now:**

Main health problems in the past (give rough dates)

Background history

Please give a brief life history by underlining the appropriate words below:

Place of birth:

Parents well or unwell?

Normal childbearing age or older parents?

Childhood -Happy or unhappy? Brothers and/or sisters? Did you get on with them - yes/no?

School - Liked or disliked?

Friends - some - lots of - or preferred own company?

Sports - liked or disliked ? If liked - what did you do most of _____?

Further education - where _____ to study what subjects _____

Work experience _____

Any other information about your life history which you think may be useful:

What would your main aims be for any treatment that I can provide for you?

Emotional life

It will be useful to know about your emotions and feelings over the last six months.

Out of a total of 10, allocate marks accordingly to show your most frequent feelings/emotions during this period:

Feelings/emotions _____ Marks

Joy, happiness, laughter _____

Worry, anxiety, concern for others _____

Grief, sense of loss, regret at what might have been _____

Sadness, tearful

Angry, irritated, resentful

Total 10 marks

Stress

(please underline as appropriate)

Are you experiencing stress from any of these sources?

Relationships - with partner - with friends - with work colleagues - with family

Study - long hours - difficult subjects - uncertainty about wisdom of choices made

Work - long hours, anti social hours, boredom, lack of opportunity/career development, too hard, wrong kind of work
Other - please specify

Energy level :Please enter "high, medium or low " for each time of day:
Morning _____ Afternoon _____ Evening _____

Please underline the words that you feel apply to you in the following sections :

Chills/Fever :

I am a hot person and don't like the heat or hot weather too much..
I am a cold person and don't like chilly weather or the cold too much.
I feel cold and hot alternately.
I sometimes feel hot and feverish - hot flushes. I have a constant feeling of slight feverishness. I get hot in the middle of the night.

Sweating:

I don't sweat except after physical exertion
I sweat sometimes - on my whole head, oily sweat on my forehead, arms and legs only, hands only, on my hands feet and chest, on my whole body.

Headaches : I don't get headaches.

I have been getting headaches recently. They last for just a short time, come and go quickly. The headaches develop gradually. They come on in the day, in the evening. They fell worse at: nape of the neck, forehead, temples sides of head, top of head, forehead, whole head. Character of pain: heavy feeling, inside head hurt brain, throbbing, boring Made worse by, cold, heat, when feeling tired.

Dizziness : None. If you experience some dizziness, is it: severe, slight/heaviness, slight when tired , sudden, gradual.

Body- Pain: If you experience any bodily aches and pains please underline the words that apply to you: Sudden pain plus chills/fever . All over and tiredness.

In joints: wandering , fixed/painful, fixed plus swelling plus numbness

In muscles: pain in all muscles plus hot flesh, pain and heaviness in muscles

Backache: continuous, dull, recent, severe plus stiffness.

severe pain, aggravated by cold/damp, better with heat, boring pain unable to turn at waist, pain extending up to shoulders .

Numbness: arms and legs, only hands and feet, fingers, elbow, arm on one side only - especially first 3 fingers

Swelling/inflammation: in joints, hot to touch, cold to touch, in ankles, water retention.

Pains: Dull. Stabbing. Fixed. Moving. Distended. Severe pain fixed in one small area.

Discomfort in Thorax and Abdomen

Chest pain, chest pain plus cough plus profuse yellow sputum.
Distension, feeling stuffy at sides of chest. Severe pain at side/s of chest.
Pain just below ribcage at front. Dull, not severe pain just below ribs at front..
Pain goes after eating. Aggravated by eating.
Bloating /Fullness in area at front below ribs, above stomach.

Pain in lower abdomen - below navel.

Abdominal pain relieved by bowel movements. Aggravated by bowel movements.

Food/diet/ Please underline any that apply:

Your condition relieved by eating . Made worse by eating. Suffering from lack of appetite.

Always feeling hungry. Feeling of fullness/bloating after eating. Preference: hot food , cold food

Diet: Please give brief outline of typical day's eating:

Breakfast:

Lunch:

Dinner: *Time of last meal of the day:*

I eat the following between meals:

Taste: Please underline any of the following tastes if they predominate in your mouth.:

Bitter, sweet, sour, salty, pungent.

Vomit: Have you been sick recently? Yes/no

If yes - was it sour, bitter, clear watery, soon after eating, sudden and loud, slow and quiet.

Constipation: I suffer from constipation.

If so complete this section by underlining relevant words:

For how long have you suffered?_____

Bowel movements: make me feel worse, make me feel better.

Always thirsty and constipated.

Small bitty stools. Stools not dry with difficult bowel movements.

Constipated with pain in abdomen.

Constipated with dry stools without thirst.

Alternate constipation and diarrhoea.

Diarrhoea: I suffer from diarrhoea. **If so, complete this section by underlining relevant words:**

Stomach pains plus diarrhoea, foul smell, no smell.

Moist stools common. Chronic diarrhoea every day.

Diarrhoea plus pains in the lower part of the abdomen.

Mucus in stools. Plus blood. Loose stools + undigested food .

Burning in anus. Stools not loose or slight loose but frequent .

Black, dark stools. Stools first then blood, bright red, splashing.

Rumbling in stomach plus loose stools.

Rumbling plus bloating but no loose stools.

Flatulence: with a foul smell. With no smell.

Urine: Normal and regular passing of water. **If not, underline as appropriate:**

Bedwetting or incontinence. Difficulty in passing water.

Frequent and copious passing of water. Frequent and scanty passing of water.

Pain: before urination, during, after.

Colour: pale, dark, turbid/cloudy. *Amount*

of urine: large, scanty

Sleep/Insomnia Do you suffer from insomnia - Yes/ No. **If yes - complete this section.**

Not able to fall asleep, but sleeps well when does. Falls asleep but wakes up many times.

Dream disturbed sleep. Restless sleep/ dreams. Wake up early morning and not able to go back to sleep.

Sleep/Lethargy: Falls asleep after eating. General lethargy and feeling of a heavy body .

Plus dizziness. Extreme lethargy plus lassitude plus feeling cold.
Lethargic stupor plus feeling feverish. Lethargic stupor and rattling in throat.

Ears: Infections in ears. Earaches. Itching, discomfort in ears.

Tinnitus: (Sounds in the ears) Yes/no, if yes...complete this section

Started suddenly Started gradually. Aggravated by pressing ears. Alleviated by pressing ears.
Noise - like a loud high pitched whistle, low pitch(like rushing water).

Deafness: Is your hearing efficient? Yes/no. If no - complete this section:

Sudden onset of deafness. Gradual onset. Long term hearing loss.

Eyes: Needle-like pain and redness and headache. Pain plus swelling plus redness.

Blurred vision and floaters (black squiggly things in front of the eyes) Pressure in eyes. Light hurts the eyes. Dryness.

Thirst and Drink: Thirsty and drinks large amounts cold water. No thirst.

Thirst with no desire to drink. Thirst, sips liquids slowly. Prefer cold drinks.
Prefer warm drinks.

Heart & Circulation. Palpitations, short of breath, poor short term memory.

High blood pressure. Low blood pressure. Suffering from a heart condition. Cold hands
Cold feet.

Marital status _____ **Children** _____ **ages** _____

Occupation _____ **Illnesses as a child** _____

Medication currently being taken

Do you smoke-----how many per day? -----Drink alcohol? _____ how much?

FOR WOMEN (Please complete if appropriate, by underlining the words that apply to you)

Are you using any contraceptive, if so - which one? _____

Menstruation:

Cycle: early, late, irregular, normal

Amount: heavy, scanty

Colour: dark red, bright red, pale, purple/blackish blood, fresh red blood
Quality: congealed/clots, watery, turbid
Pain: before period, during, after
Pre Menstrual Tension? Yes/no

Leucorrhoea:

Colour: white discharge, yellow, greenish, red and white, yellow and pus and blood (after menopause)
Consistency: watery, thick
Smell: fishy, leathery

For mothers or would-be mothers...

Pregnancy: Problem with fertility. Vomiting during pregnancy
Miscarriage before 3 months, after 3 months

Childbirth: nausea, heavy bleeding after delivery
Sweating and fever after delivery. Post natal depression.

Other problems of a gynaecological nature - please describe:

Any other information which will help me to help you: