

Acupuncture Solutions

Cory Walsh, Lic.Ac.

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MD: 17531 Country View Way • Mount Airy, MD 21771

MA: 528 Loring Avenue • Salem, MA 01970

Kidney Yin Deficiency (11)

	Yes	No
Do you have lower back weakness, soreness or pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have knee problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have ringing in your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair prematurely gray?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your midcycle fertile cervical mucous scanty or missing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles around or under your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as afraid a lot?	<input type="checkbox"/>	<input type="checkbox"/>

[Tongue: Lacks coating; shiny or peeled]

Kidney Yang Deficiency (12)

	Yes	No
Do you have lower back pain premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Is your low back sore or weak?	<input type="checkbox"/>	<input type="checkbox"/>
Are your feet cold, especially at night?	<input type="checkbox"/>	<input type="checkbox"/>
Are you typically colder than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Is your libido low?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often fearful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up at night or early in the morning to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently? Is the urine diluted and/or profuse?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early morning loose, urgent stools?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have profuse vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood tend to be dull in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel cold cramps that respond to a heating pad?	<input type="checkbox"/>	<input type="checkbox"/>

[Tongue: Pale, moist and swollen]

Heart Deficiency (7)

	Yes	No
Do you wake up early and have trouble getting back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart palpitations, especially when anxious?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>
Do you seem low in spirit or lacking in vitality?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you fidget?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat excessively, especially on your chest?	<input type="checkbox"/>	<input type="checkbox"/>

[Tongue: Red; central crack extending to tip]

Cold Uterus (3)

	Yes	No
Is your lower abdomen cooler to the touch than the rest?	<input type="checkbox"/>	<input type="checkbox"/>

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Blood Stagnation (15)

	Yes	No
Is your menstrual flow ever brown or black in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel midcycle pain around your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have painful, unmovable breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose or spider veins?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemangiomas (cherry-red spots) on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Does your complexion appear dark and “sooty”?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain clots?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a diagnosis of endometriosis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>
Is your lower abdomen tender to palpation (resisting touch)?	<input type="checkbox"/>	<input type="checkbox"/>
Can you feel any abnormal lumps in your lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have piercing or stabbing menstrual cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have periodic numbness of your hands and feet (especially at night)?	<input type="checkbox"/>	<input type="checkbox"/>
[Tongue: Dark, dark spots, engorged sublingual veins]		

Excess Heat (8)

	Yes	No
Is your pulse rate rapid?	<input type="checkbox"/>	<input type="checkbox"/>
Are your mouth and throat usually dry?	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty for cold drinks most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel warmer than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up sweating or have hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you break out with red acne (especially premenstrually)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a short menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal irritation or rashes?	<input type="checkbox"/>	<input type="checkbox"/>

Dampness (8)

	Yes	No
Do you feel tired and sluggish after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have fibrocystic breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cystic or pustular acne?	<input type="checkbox"/>	<input type="checkbox"/>
Do have urgent, bright or foul-smelling stools?	<input type="checkbox"/>	<input type="checkbox"/>
Does your menstrual blood contain stringy tissue or mucous?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infections and vaginal itching?	<input type="checkbox"/>	<input type="checkbox"/>
Do your joints ache, especially with movement?	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>
[Tongue: Wet, slimy coating]		

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Spleen Qi Deficiency (28)

	Yes	No
Are you often fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Is your energy lower after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated after eating?	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose stools, abdominal pain, or digestive issues?	<input type="checkbox"/>	<input type="checkbox"/>
Are your hands and feet cold?	<input type="checkbox"/>	<input type="checkbox"/>
Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heaviness or grogginess in the head?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot without exerting yourself?	<input type="checkbox"/>	<input type="checkbox"/>
Is your menstruation thin, watery, profuse or pinkish in color?	<input type="checkbox"/>	<input type="checkbox"/>
Are you more tired around ovulation or menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever spot a few days or more before your period?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with uterine prolapse?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often sick, or do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pale, yellowish complexion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cramps which include a bearing-down sensation in the uterus?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dizzy, light-headed or do you experience visual changes when you stand quickly?	<input type="checkbox"/>	<input type="checkbox"/>
[Tongue: Swollen, with teeth marks on the sides]		

Damp Heat (3)

	Yes	No
Do you have signs of excess heat and/or dampness as indicated on pages 2 and 3?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have foul-smelling, yellow or greenish vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>

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Blood Deficiency (9)

	Yes	No
Are your menses scanty and/or late?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry, flaky skin?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to getting chapped lips?	<input type="checkbox"/>	<input type="checkbox"/>
Are your fingernails or toenails brittle?	<input type="checkbox"/>	<input type="checkbox"/>
Are you losing hair on your head (not in patches, but all over)?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair brittle or dry?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diminished nighttime vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy or light-headed around your period?	<input type="checkbox"/>	<input type="checkbox"/>
Are your lips or the inner corners of your eyes, pale in color?	<input type="checkbox"/>	<input type="checkbox"/>
[Tongue: Pale]		

Liver Qi Stagnation (16)

	Yes	No
Are you prone to emotional depression?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to anger and/or rage?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become irritable premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated or irritable around ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Are your breasts sensitive/sore at ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in or discharge from your nipples?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of premenstrual breast distention or pain?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with elevated prolactin levels?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become bloated premenstrually?	<input type="checkbox"/>	<input type="checkbox"/>
Are your pupils usually dilated and large?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep at night?	<input type="checkbox"/>	<input type="checkbox"/>
Are your menses painful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel menstrual cramps in the external genital area?	<input type="checkbox"/>	<input type="checkbox"/>
Is the menstrual blood thick, dark or purplish in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heartburn or wake up with a bitter taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
[Tongue dark or purplish]		