

SELF DETERMINATION OF CONSTITUTION

1	How is your mother's character ?	<input type="checkbox"/> Nervous	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Calm and quiet
2	How is your father's character ?	<input type="checkbox"/> Nervous	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Calm and quiet
3	How is your digestion ?	<input type="checkbox"/> Unstable	<input type="checkbox"/> Fast	<input type="checkbox"/> Slow
4	When does discomfort manifest?	<input type="checkbox"/> During the empty stomach	<input type="checkbox"/> During the digestion	<input type="checkbox"/> Just after the meal
5	What kind of stomach complains do you have?	<input type="checkbox"/> Excess gas	<input type="checkbox"/> Acidity	<input type="checkbox"/> Indigestion
6	What taste do you like ?	<input type="checkbox"/> Hot, strong	<input type="checkbox"/> Bitter, sweet	<input type="checkbox"/> Sweet, salty
7	What food are you allergic to, have intolerance or is difficult to digest ?	<input type="checkbox"/> Coffee, Green Capsicum, Beans	<input type="checkbox"/> Milk, garlic, alcohol, fatty food	<input type="checkbox"/> Carbohydrate, cucumber, raw vegetables
8	Which organs and body parts are weak or sensitive ?	<input type="checkbox"/> Heart, colon, skin, chest and left shoulder	<input type="checkbox"/> Liver, eyes, gall bladder, small intestine, right shoulder, headache	<input type="checkbox"/> Kidney, urinary bladder, spleen, stomach, lower back, legs
9	Which sensory organs are weak ?	<input type="checkbox"/> Ear, tongue, skin	<input type="checkbox"/> Eyes, skin, throat	<input type="checkbox"/> Nose, lips, excess mucus
10	How is your body temperature ?	<input type="checkbox"/> Cold	<input type="checkbox"/> Hot	<input type="checkbox"/> Cold and humid
11	How is your body structure ?	<input type="checkbox"/> Thin, short or tall with thin	<input type="checkbox"/> Medium size with broad shoulders	<input type="checkbox"/> Obesity and big heap
12	What is your color of hair and skin?	<input type="checkbox"/> Dark or grey, fragile, dry and rough skin	<input type="checkbox"/> Greasy hair, red, curly, dry and red skin	<input type="checkbox"/> Strong and black hair, straight, moist and smooth skin
13	What climate gives you trouble ?	<input type="checkbox"/> Cold wind	<input type="checkbox"/> Hot	<input type="checkbox"/> Humid and dampness
14	How many times do you need to take a bath in a week ?	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Some times
15	How is your sleeping ?	<input type="checkbox"/> Short, Nightmare, insomnia	<input type="checkbox"/> Sleepy in the day and less in the night	<input type="checkbox"/> Profound sleeping
16	What are your dreams about?	<input type="checkbox"/> Flying, blue, black colors,	<input type="checkbox"/> Violence, red or yellow color	<input type="checkbox"/> Falling or going down, green or water
17	How is your mental attitude ?	<input type="checkbox"/> Emotional, sentimental	<input type="checkbox"/> Aggressive, fearful	<input type="checkbox"/> Depressed, melancholic
18	What kind of psychological or physical problems do you have ?	<input type="checkbox"/> Hyper sensitivity, emotional anxiety and nervousness	<input type="checkbox"/> Headache, diarrhea, infection, fever inflammation	<input type="checkbox"/> Indigestion, water retention, non-inflammatory chronic disorders
19	How is your tongue?	<input type="checkbox"/> Red and dry	<input type="checkbox"/> Yellowish and thick cover	<input type="checkbox"/> Pale, whitish with thick saliva
20	How is your bowel movement ?	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tendency to diarrhea	<input type="checkbox"/> Normal
	Results	— Wind	— Bile	— Phlegm