Kimura Acupuncture
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Original Date: _____
Date Revised: _____

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become a part of your medical record.

Name: _____ M / F Date of Birth: _____

Referring Doctor: _____ Date of Last Physical Exam: _____

Complaint

Complaint: _____

Onset: ¦Sudden ¦Gradual How long have you had this condition? _____

Have you seen a physician? ¦Yes ¦No If yes, diagnosis was: _____

What other therapies are you doing or have you done to manage it?

¦Physical Therapy ¦Chiropractic ¦Medications ¦Other (Please specify: _____)

Rate the intensity of PHYSICAL DISCOMFORT associated with the complaint.

(None) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Rate the intensity of EMOTIONAL DISCOMFORT associated with the complaint.

(None) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Are the symptoms relieved by anything? ¦Yes ¦No If yes, please specify: _____

Are the symptoms worsened by anything? ¦Yes ¦No If yes, please specify: _____

On the diagram, please shade in the areas where you feel symptoms associated with your complaints.

A = ACHE

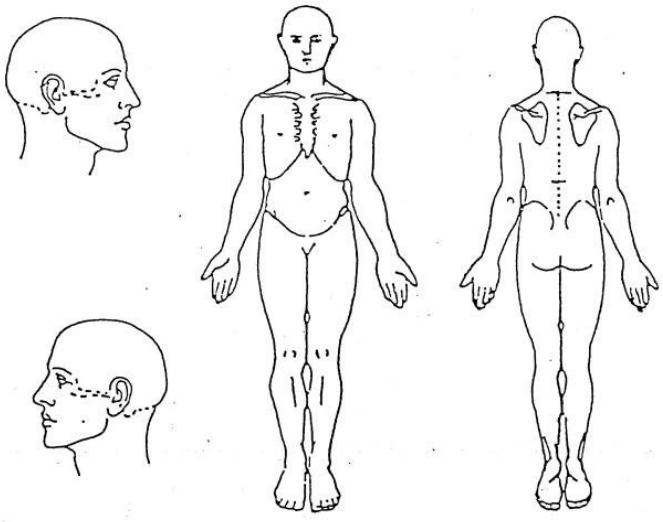
B = BURNING

P = PINS & NEEDLES

S = STABBING

N = NUMBING

O = OTHER



Personal Health History

List any medical problems that doctors have diagnosed: _____

_____

Surgeries, accidents, and other hospitalizations and problems.

Year	Reasons	Any issues afterwards?

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Names of Drugs	What for?	Strength & Frequency Taken

Allergies to Medications

Names of Drugs	Reaction You Had

Health Habits

Diet: Number of meals you eat in an average day? _____times / day

Water intake: □ High □ Medium □ Low

You prefer drinks to be: □ Cold □ At room temperature □ Warm / Hot

Are you a vegetarian? □ Yes □ No

Caffeine: □ None □ Coffee □ Tea □Cola/Soda

How many cups/cans per day? _____cups/cans per day

Alcohol: Do you drink alcohol? □Yes □ No

If yes, how many drinks per week? _____ drinks per week

Does drinking have an impact on your complains? □ Yes □ No

If yes, please describe: _____

Tobacco: Do you use tobacco? □ Yes □ No

□ Cigarettes _____pks./day □ Chew _____ / day □ Pipe _____/dayCigars / day

Drugs: Do you currently use recreational or street drugs? □ Yes □ No

Does the use of drugs have an impact on your complaints? □ Yes □ No

If yes, please describe: _____

Family Health History

Please note all major illnesses in your immediate family, such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, and orthopedic disorders.

Relationship	Age	Major Illnesses
Father:	_____	_____
Mother:	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Women Only

Age at onset of menstruation: _____ years old Date of last menstruation: _____

Menstrual cycle: Every _____ days

Symptoms List

Circle any problem, disease, or symptom you have now. **Underline** items that affected you in the past.

AIDS / HIV	Cancer	Lyme Disease	Seizures
Alcoholism	Diabetes	Multiple Sclerosis	Tuberculosis
Allergies	(What kind? _____)	Polio	Lymph nodes removed
Rheumatic Fever	Rheumatism	Crohn's Disease	Hepatitis A / B / C
Herpes	Hashimoto's Disease (Thyroid)	Birth Trauma	

Skin

Rashes	Change in Hair / Skin Texture	Dryness	Dandruff
Eczema	Hair Loss	Itching	Night Sweats
Acne	Purpura	Excess Sweating	Other: _____

Head

Headache	Migraines	Dizziness	Memory Loss
Concussions	Other: _____		

Eyes

Blurred Vision	Pain	Redness	Dryness
Floaters	Night Blindness	Other: _____	

Ears, Nose, and Throat

Poor Hearing	Ringing	Frequent Ear Infections	Frequent Cold
Sinus Trouble	Nosebleeds	Drainage	Sore Throat
Difficulty Swallowing	Enlarged Thyroid	Other: _____	

Mouth

Gum Problems	Teeth Problems	Tongue / Lip Sores	Jaw Clicking / Pain / TMJ
Unusual Taste (_____)			

Respiration

Asthma	Bronchitis	Chest Pain	Cough
Coughing Blood	Emphysema	Difficulty Breathing	Phlegm
Wheezing	Other: _____		

Heart and Thorax

Palpitation	High Blood Pressure	Low Blood Pressure	Tightness in Chest
Prior Heart Attack	Heart Disease	Pacemaker	Other: _____

Circulation

Bruise Easily	Cold Hands and Feet	Fainting	Varicose Vein
Anemia	Other: _____		

Gastrointestinal

Poor Appetite	Bad Breath	Excessive Hunger	Excessive Thirst
Belching	Heartburn	Gas	Nausea
Vomiting	Abdominal Pain/Cramps/ Stomach Pain	Constipation	Loose Stools or Diarrhea
Black Stools	Hemorrhoids	Rectal Pain	Colitis or IBS
Gallbladder Trouble	Other: _____		

Urogenital

Frequent Urination	Difficulty Urinating	Burning Urination	Frequent UTIs
Dribbling of Urine	Waking to Urinate (_____ times / night)	Retention of Urine / Scanty Urine	Bedwetting
Pause of Flow in Urination	Itching of Genitals	Other: _____	

Energy Level

Low Energy	Excessive Energy	Fluctuates a Lot	Energy Drop in the Afternoon
Other: _____			

Sleep

Insomnia	Drowsiness	Night Sweats	Difficulty Falling Asleep
Difficulty Staying Sleep	Excessive Dreaming	Not Enough Sleep	Other: _____

Neurological

Stiff Neck	Lower Back Soreness / Weakness	Shoulder Trouble	Spinal Curvature
Pain Between Shoulders	Knee Trouble / Pain	Swollen Joints	Painful Joints
Hip Pain	Arthritis	Hand / Wrist Pain	Sprain
Hernia	Numbness or Tingling	Sciatica	Paralysis
Other: _____			

Emotional Issues

Depression	Mania / Bipolar	Anxiety	Bad Temper
Mood Swings	Stressed	Other: _____	

Men's Issues

Prostate Problems	Discharge	Impotence	Frequent Seminal Emissions
Fertility Problems	Ejaculatory Problems	Painful / Swollen Testicles	Vasectomy
Other: _____			

Women's Issues

Painful Periods	Cramps or Backache	Fertility Problems	Ovarian Cysts
Fibrocystic Breasts	Tubal Ligation	Breast Tenderness	Endometriosis
Abnormal Bleeding	Low Sex Drive	Other: _____	

Is there anything you would like to add?

_____

_____

_____

_____