



Kimura Acupuncture
637 Willis Ave
Williston Park, NY 11596
516-882-1292

www.kimura-acupuncture.com

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.

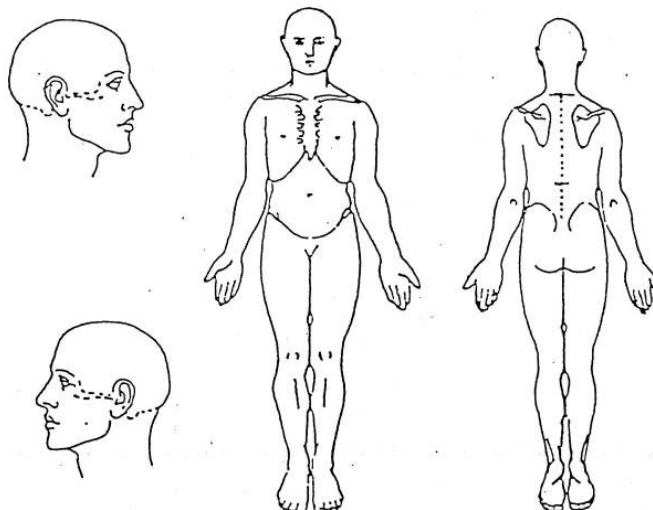
(None) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

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 \_\_\_\_\_/day Cigars / 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<br>(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
Floater	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?

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