



Kimura Acupuncture
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INITIAL CONSULTATION QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____ (BMI: _____)

1. What kind of food issues and weight problems do you have?

2. How much weight do you want to lose?

3. Please describe what types of diet/weight programs you have done in the past.
 - What did you like about what you have done before?

 - What did you dislike about it and what did not work?

4. If you could design your own program, what would be the most important elements in it?

5. What habits do you want to change?

6. What unhealthy or addictive food choices are you currently making?

7. Do you ever find yourself eating when not hungry? Y / N

8. Do you feel out of control with food sometimes? Y / N

9. Do you have binges? If yes, how often? Y / N

10. What do you do afterward (e.g. fast, diet, exercise, vomit?)

11. Do you crave or binge on certain types of foods at, certain times of the day? Y / N

If yes, please describe.

12. Why do you want to resolve these issues?

13. If these issues were resolved, how would you feel?

14. How do you feel about your body?

15. When do you feel satisfied with yourself (Are you ever satisfied with yourself?)

16. Do you find that you know what to do (eat) but cannot seem to do it? Y / N

17. Have you engaged in an exercise program recently? Y / N

If yes, please describe.

18. What type of physical activities do you enjoy doing? Y / N

Please describe.

19. Why don't you do the physical activities you enjoy doing

(e.g. time, energy, other people's needs come first)

20. If you were the weight you want to be and enjoyed a healthy body, how would you act differently?

21. How would your life feel to you? How would you feel to yourself?