Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**KAM Acupuncture**

Health History Questionnaire

*All of your answers will be held confidential.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_

Gender: M / F / Other Height: \_\_\_\_\_\_ Weight: \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to You :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated by acupuncture or Oriental medicine before: Yes  No

**Describe your main complaint, including location and when, how and why it began.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How frequently does this problem bother you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When it does bother you, how long does the episode last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything make it better/worse — Hot, Cold, Damp, Wind, Movement, Rest, Touch/Pressure, Stress, Drugs? Better: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worse : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Pain) scale currently: \_\_\_/10

*(Best=0, Worst=10)*

If pain is involved, what is the quality? Dull Achy Sharp/Stabbing Burning Throbbing Other: \_\_\_\_\_\_\_\_\_\_\_\_

*(Circle best answer)*

If pain is involved, does the pain: Move around Stay in one place

Have you been diagnosed for this problem? If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kinds of treatments have you tried? Western Medicine Acupuncture Herbs

Massage Physical Therapy Chiropractic Reiki Homeopathy

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary complaints you’d like help with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any medications/vitamins/supplements/herbs you are currently taking (past 6 months):

Medication Dosage Reason for taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any allergies (drugs/food/chemicals/environmental/metals): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any hospitalizations/surgeries (including dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any significant trauma (falls/auto accidents): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have a regular exercise program? No Yes If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you follow any type of special diet (vegetarian/vegan/medical-related/other)?

No Yes If yes, what type of diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Please describe your average daily diet:

Morning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Afternoon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_ How much caffeine do you drink per day? \_\_\_\_\_

How much alcohol per week? \_\_\_\_\_ Do you smoke? No / Yes How many cigarettes/cigars per day? \_\_\_\_\_

Please describe any use of drugs for non‐medical purposes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of colds/flu: (# per month/year/season): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Personal Medical History of Significant Illnesses: Asthma Allergies Diabetes

Cancer Stroke Heart disease High Blood Pressure Seizures Hepatitis

Rheumatic Fever Thyroid disease Venereal disease HIV EBV

Autoimmune Disease Candida Alcoholism Mental Illness

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical History of Significant Illnesses: Asthma Allergies Diabetes

Cancer Stroke Heart disease High Blood Pressure Seizures Hepatitis

Rheumatic Fever Thyroid disease Venereal disease HIV Arthritis

Autoimmune Disease Alcoholism Mental Illness Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hot/Cold:**

Do you have a tendency to feel: Hotter than others Colder than others Neither

Are only your hands and feet cold: No Yes If yes, is it your: hands / feet / both   
Any abnormal sweating? No Yes If yes, is it: constant / nightsweats / menopausal hot flashes   
**Skin/Hair: (Check all that apply)**

Rashes Ulcerations Hives Itching Eczema Pimples Moles Dandruff Hair Loss

Any other changes in hair or skin? (texture/color/premature graying/sudden hair loss) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head, Eyes, Ears, Nose, and Throat:**

***Headaches*** *(where appropriate, circle best answer)*

Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: Forehead / Temples / Behind Eyes / Top of Head / Back / Sinus

Frequency: \_\_\_\_\_ X per: day / week / month (Pain) scale currently: \_\_\_/10 *(Best=0, Worst=10)*

Is it (Better/ Worse / Neither) when you apply pressure to the headache?

Is it worse with (Improper Eating / in the Morning / in the Evening / Bright Lights / Noise)?

Do they come at a certain time of day? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do they come (Before / After / During ) your period?

What is the Quality of the Pain? Dull / Achy / Sharp & Stabbing / Throbbing / Pressure / Whole Head Heavy

***Eyes***

Dry Itchy Watery Red Burning Painful Cataracts  
***Ears***

Any ringing in ears? No Yes If yes, what is the pitch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Nose***

Any nasal issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Throat***

Recurrent Sore Throats Dry Itchy

***Other***

Lip sores Tongue sores Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Respiratory: (Circle all that apply)**

Shortness of Breath Cough Coughing Blood Asthma Bronchitis Pneumonia

Pain with a deep breath Difficulty in breathing when lying down

Production of phlegm (what color?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appetite:**

How is your appetite?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any unusual taste in your mouth: No Yes If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a sensation of feeling “weighed down” or heaviness in your body? No Yes

Have you gained or lost weight in the last 6-12 months? No Yes If so, I’ve Gained / Lost \_\_\_\_\_\_\_\_ lbs.

Crave particular flavors? Sweets / Sour / Bitter / Spicy / Greasy / Fried / Salty

**Thirst:**

Are you frequently thirsty? No Yes Do you have thirst with little desire to drink? No Yes

Do you prefer (Hot / Cold) beverages?

**Gastrointestinal: (Circle all that apply)**

Indigestion Belching Bad Breath Vomiting Nausea Abdominal Pain or Cramps Bloating after eating Gas Ulcer Eating Disorders Recurrent/Chronic Antibiotic Use

Rectal Pain Diarrhea Constipation Chronic Use of Laxatives/Stool Softeners

Hemorrhoids (Are they currently bleeding? No Yes) Black/Bloody Stools Parasite history

Any other stomach or intestinal problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you move your bowels? \_\_\_\_\_\_\_\_\_ times per (Day / Week)

What is the consistency of your stools? Loose-Diarrhea / Hard-Constipated / Watery / Formed / Thin

**Genitourinary: (Circle all that apply)**

Pain on Urination Urgency to Urinate Decrease in Flow Frequent Urination Unable to hold urine

Blood in Urine Poor Sex Drive Kidney Stones Prostate Problems Difficulty Urinating Genital Sores Erection Difficulty

Do you wake up at night to urinate? No Yes If so, how often? \_\_\_\_ times per night

Any particular color to your urine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you take vitamins? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:**

How many hours do you sleep? \_\_\_\_ per night Trouble falling asleep? Yes / No

Trouble staying asleep/wake-ups during the night? No / Yes Why? Urinate / Restless / Other: \_\_\_\_\_\_\_\_\_\_\_\_  
How many times do you wake per night? \_\_\_\_\_ Specific time you usually wake up during the night? \_\_\_\_\_\_\_\_

Do you feel well-rested in the AM? Yes / No

**Energy Level: (0=Low, 10=High)**

How is your overall Energy Level: \_\_\_\_\_/10

After exercise? Better / Same / Worse After meals? Better / Same / Worse

Fatigue…In the morning? Yes / No In the Afternoon? Yes / No When weather is Damp / Hot / Cold

**Musculo-skeletal: (Circle all that apply)**

Neck Pain Muscle Pains Knee Pain Back Pain Muscle Weakness Foot/Ankle Pain

Hand/Wrist Pain Shoulder Pain Hip Pain Other joint/ bone problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neuro-psychological: (Circle all that apply)**

Dizziness Lack of Coordination Loss of Balance Poor Memory Anxiety Easily susceptible to stress Depression Bad Temper Concussion Seizures Areas of Numbness Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotional State:**

What is your general state of emotion?Circle the most appropriate emotion(s).

Happiness Sadness Worry Stress Anger Irritability Obsession Pensiveness Fear Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your overall stress level : \_\_\_/10 Are you comfortable expressing anger? Yes / No

**\*\*\*Men may skip this section\*\*\***

**Reproductive and Gynecological:**

Age of first period \_\_\_\_ Average length of period \_\_\_\_days Length of your cycle \_\_\_\_days

First date of last period \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of pregnancies \_\_\_\_ # of births \_\_\_\_

Any notable changes in your cycle in the past 6-12 months? Yes / No How so?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopause (Age) \_\_\_\_

Do you use birth control now? Yes / No If so, what type/how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ever taken birth control or been on Estrogen replacement therapy? Yes / No How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had problems with fertility?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle all that apply:

Cramping (Before / During / After Period) Little / Excessive Flow Absence of period Clotting

Mood changes (Before / During / After Period ) Tender Breasts Vaginal Dryness History of STDs

Excess Facial Hair Vaginal discharge/color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Section below for acupuncturist use only.***

General observations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Tongue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pulse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment Plan (including adjuncts):