

**LESLI DALABA, L.Ac.**  
**HEALTH HISTORY QUESTIONNAIRE**

**All off the information that you provide on this form and in session is kept strictly confidential, and will not be released without your written permission.**

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

PHONE: W \_\_\_\_\_ H \_\_\_\_\_ E-MAIL (optional) \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PHYSICIAN/CLINIC \_\_\_\_\_ REFERRED BY \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

Have you previously received acupuncture? \_\_\_Yes \_\_\_No    Do you have a history of fainting? \_\_\_Yes \_\_\_No

Do needles make you nervous? \_\_\_Yes \_\_\_No    Do you have a pacemaker? \_\_\_Yes \_\_\_No

Do you bleed or bruise easily? \_\_\_Yes \_\_\_No    Women: Any chance you are pregnant? \_\_\_Yes \_\_\_No

Main condition/s you would like to resolve \_\_\_\_\_

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Time of Onset and Cause/s (if known) of your condition/s \_\_\_\_\_

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Please list any diagnoses you have been given \_\_\_\_\_

What treatments have you tried, & did they help/worsen your condition? \_\_\_\_\_

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Past Medical History (please include dates) Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_

Hepatitis \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart disease \_\_\_\_\_

Thyroid Disease \_\_\_\_\_ Seizures \_\_\_\_\_ Other \_\_\_\_\_

Surgeries (type and date) \_\_\_\_\_

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Significant Traumas (accidents, falls, etc.) \_\_\_\_\_

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Major Dental Work \_\_\_\_\_

Allergies \_\_\_\_\_

Medicines (prescribed & non-prescribed), Herbs, Vitamins, etc. taken consistently the last two months \_\_\_\_\_

Occupational Stress? (chemical, physical, psychological) \_\_\_\_\_

Describe your average week's exercise \_\_\_\_\_

Are you on a restricted diet? No \_\_\_ Yes \_\_\_ Describe \_\_\_\_\_

Please describe your average daily diet: Morning \_\_\_\_\_

Afternoon \_\_\_\_\_ Evening \_\_\_\_\_

Cigarette Smoking (brand, quantity, & years) \_\_\_\_\_

How much coffee, tea, cola & diet soda do you drink per week? \_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_

-----PLEASE CHECK ANY SYMPTOMS THAT YOU EXPERIENCE FREQUENTLY -----

**GENERAL**

- \_\_\_ Night sweats
- \_\_\_ Sweat easily
- \_\_\_ Bleed or bruise easily
- \_\_\_ Low energy/fatigue
- \_\_\_ Tremors
- \_\_\_ Poor balance
- \_\_\_ Weight gain
- \_\_\_ Weight loss

**SKIN AND HAIR**

- \_\_\_ Rashes
- \_\_\_ Itching
- \_\_\_ Dandruff
- \_\_\_ Eczema
- \_\_\_ Acne
- \_\_\_ Recent moles
- \_\_\_ Ulcerations
- \_\_\_ Hair loss
- \_\_\_ Other \_\_\_\_\_

- \_\_\_ Sinus congestion
- \_\_\_ Post-nasal drainage
- \_\_\_ Teeth grinding
- \_\_\_ Jaw pain
- \_\_\_ Recurring sore throat
- \_\_\_ Sores on tongue, lips, or cheek
- \_\_\_ Other head/throat problem: \_\_\_\_\_

**GENITO-URINARY**

- \_\_\_ Pain with urination
  - \_\_\_ Frequent urination
  - \_\_\_ Blood in urine
  - \_\_\_ Dribbling
  - \_\_\_ Unable to hold urine
  - \_\_\_ Kidney stones
  - \_\_\_ Change in sexual drive
  - \_\_\_ Recurring urinary infection
  - \_\_\_ Genital infection
  - \_\_\_ Sores on genitals
- How often do you wake up to urinate?  
\_\_\_\_\_

**NEUROPSYCHOLOGICAL**

- \_\_\_ Seizures
- \_\_\_ Areas of numbness
- \_\_\_ Difficulty sleeping/falling asleep
- \_\_\_ Irritability
- \_\_\_ Violent temper
- \_\_\_ Vertigo
- \_\_\_ Lack of coordination
- \_\_\_ Loss of balance
- \_\_\_ Depression
- \_\_\_ Easily susceptible to stress
- \_\_\_ Poor memory
- \_\_\_ Poor concentration
- \_\_\_ Anxiety

Other neurological or psychological problems \_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving counseling?  
\_\_\_ Yes \_\_\_ No

**HEENT**

- Headaches
- Migraines
- Facial pain
- Blurry vision
- Facial pain
- Spots in front of eyes
- Eye pain
- Eye dryness
- Cataracts
- Changes in vision
- \_\_\_\_\_
- Hearing loss
- Ringing in ears
- Nose bleeds

**MUSCULOSKELETAL**

- Neck pain
- Shoulder pain
- Upper-mid back pain
- Low back pain
- Elbow pain
- Wrist pain
- Hand pain
- Knee pain
- Foot/ankle pain
- Muscle weakness

**CARDIOVASCULAR**

- High blood pressure
- Low blood pressure
- Chest pain/discomfort
- Heart palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood clots
- Difficulty breathing
- Other heart or circulatory problem: \_\_\_\_\_

**GASTROINTESTINAL**

- Poor appetite
- Belching
- Flatulence
- Bad breath
- Heartburn
- Nausea
- Vomiting
- Bloating
- Abdominal discomfort
- Diarrhea
- Constipation
- Intestinal cramps
- Blood in stools
- Rectal pain
- Hemorrhoids

**OBGYN**

- Number of births
- Premature births
- Number of miscarriages
- Number of abortions
- Age at first menses
- Age at menopause
- Average number of days of bleeding
- Average length of complete cycle
- Very light flow
- Very heavy flow
- Skipped periods
- Painful periods
- Heavy clotting
- History of: P.I.D.  Fibroids  Ovarian cyst  Urinary infection
- Yeast infection  Other \_\_\_\_\_

Please check changes you often notice before(B), during(D), after(A) menses:

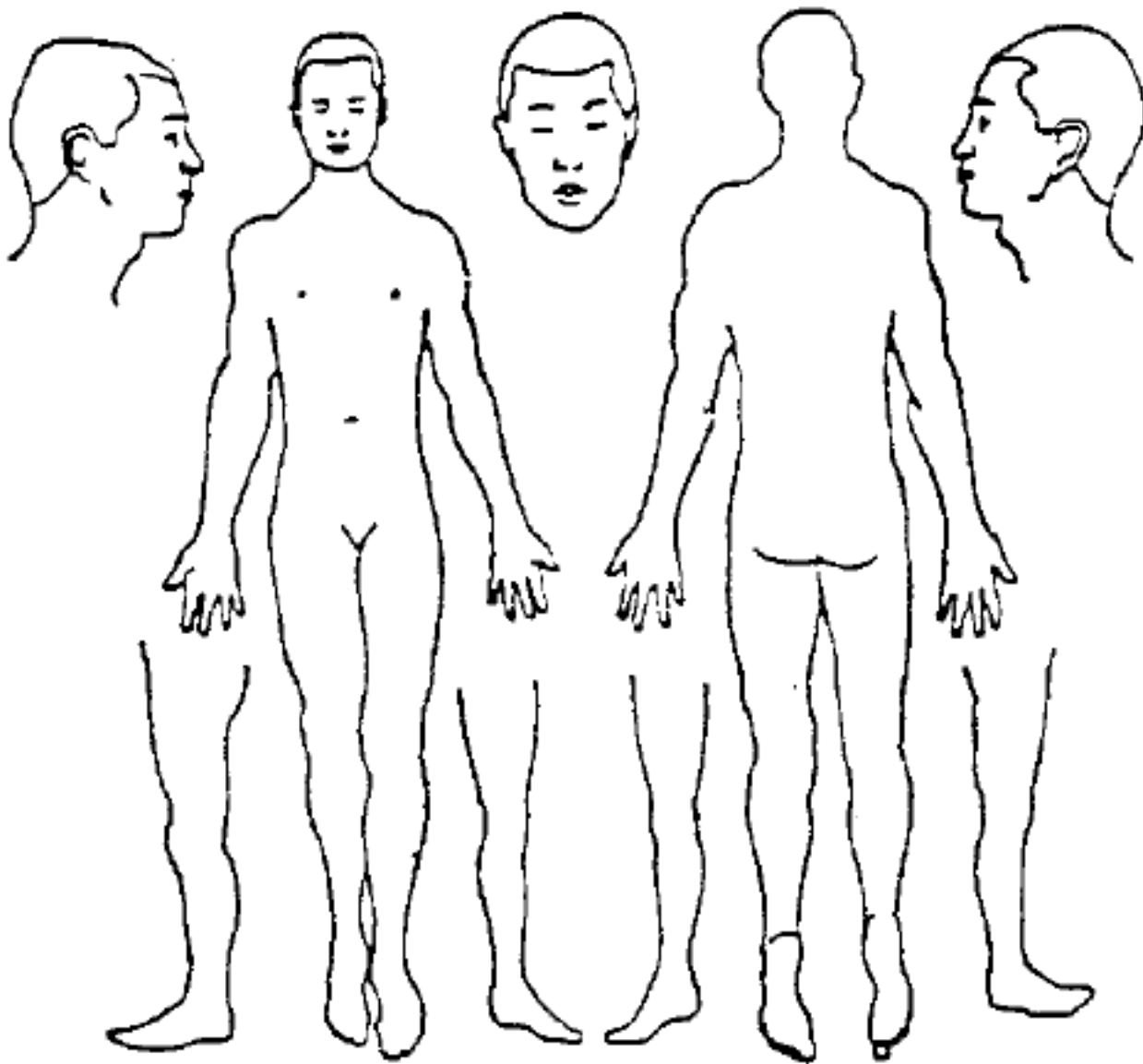
- Headaches
- Irritability, anger
- Fatigue
- Food cravings
- Breast pain
- Diarrhea
- Digestive distress

Please show your average energy level the past few weeks:

Can barely move

have energy to spare

On the diagrams below, please circle all areas that are causing you pain or distress.



**Comments:** Are there any additional symptoms or issues that you would like to discuss?

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