



# Visconti Acupuncture & Natural Medicine

Welcome!

Enclosed you will find an intake form to fill out at your convenience. Please answer as much of the information as possible as the more information we have the better we can address your concerns. A diet diary is included. Please write down what you eat, when and if you notice any physical, mental or emotional responses to your foods (for example: headache or sinus congestion following drinking milk). Include bowel movements (BM) and any other digestive issues.

Our goal is to assure that all of your needs are met and all of your questions are answered so please allow approximately an hour and a half for the first visit. Follow-up visits usually last 30 minutes to 1 hour. Together we will review your history, establish your goals and decide on any further testing you may need either from our office or from your primary care physician. We will then create an effective treatment plan most appropriate for your individual health needs and that is realistic for you. Often, the first few visits are more frequent to ensure that the changes and protocols we create are working the way we want them to and are not overly stressful for you. After that, follow up visits are usually less frequent.

Our practice includes the use of Acupuncture and Traditional Chinese Medicine, Nutrient/Herb Injection Therapy, Therapeutic Nutrition and Detoxification, Herbal and Homeopathic Medicine, Stress Management and Clinical Hypnosis. Some of the services we provide are: Functional Medical Assessment and Testing, Health Optimization Programs, Vitamin and Supplement Evaluation, Detoxification Programs, Heart Disease and Cancer Co-Management and Natural Health Consultations for Healthcare Professionals. Since our focus is on you as a whole person and on creating a plan that will improve your body's function and self-healing ability, we can help address your health concerns from back pain to the common cold to menopause, heart disease or cancer. If you have any other questions please call the office at the number below. Please send the forms back to us before your appointment if possible so we can make the most of your visit. We look forward to meeting with you.

Sincerely,

Michael A. Visconti A.P.

\*We schedule patients one at a time so if you need cancel or change your appointment please give us at least 24 hours notice so we can provide the time to another. You will be charged for a **full office visit** in case of a no show or late cancellation. (A one time exception will be made if you reschedule for the following week in case of an emergency.)

235 Citrus Tower Boulevard, Suite 105 • Clermont, FL 34711

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# Visconti Acupuncture & Natural Medicine

Name _____	Age _____	D.O.B. _____	Sex M F	Date _____
Address _____		City _____	State _____	Zip _____
Telephone (Home) _____		(Work) _____		
Occupation _____		Email address _____		
Employer (Name and Address) _____				
Education _____		Referred by _____		
Are you;	Married _____	Separated _____	Divorced _____	Single _____ Cohabiting _____
Live with:	Spouse _____	Parents _____	Relatives _____	Friends _____ Alone _____ Other _____
Next of Kin (or emergency name) _____			Relationship _____	
Address _____				
Telephone (Home) _____		(Work) _____		

**NOTE:** Total health care is only possible when there is a complete picture of the patient physically, mentally, emotionally and spiritually. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire.

When, where and by whom did you last receive medical health care? \_\_\_\_\_  
 \_\_\_\_\_

In your opinion, what are your most important health problems? List in order of importance. Indicate which is/are of the most immediate concern to you.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List stresses, lifestyle changes, traumatic events in your life. Indicate those that you can identify as having caused or clearly aggravated your health problems. Use a separate page, if necessary to be complete.

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

## PAST MEDICAL HISTORY

What childhood illnesses have you had?

Rubella (German 3 day measles) \_\_\_\_\_ Measles (2 week) \_\_\_\_\_ Mumps \_\_\_\_\_ Chickenpox \_\_\_\_\_ Roseola \_\_\_\_\_  
 Whooping cough \_\_\_\_\_ Polio \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ Asthma \_\_\_\_\_ Eczema \_\_\_\_\_  
 Diphtheria \_\_\_\_\_ Other \_\_\_\_\_

## IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus shot (not antitoxin)	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other _____	



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## HEALTH HISTORY

NOW PAST NEVER

Allergies  
   Anemia  
   Arthritis  
   Asthma  
   Alcoholism  
   Bleeding  
   Cancer  
   Candida (yeast)  
   Colitis  
   Drugs/Alcohol use\*  
   Eczema  
   Emphysema  
   Headache  
   Heart murmur\*  
   High Blood Pressure

NOW PAST NEVER

Injury (serious)  
   Kidney Disease  
   Liver Ds./jaundice  
   Overweight  
   Pneumonia  
   Polio  
   Rheumatism  
   Thyroid  
   (Hyper/Hypo)  
   Tuberculosis  
   Venereal Disease  
   Others (specify)

(\*) Please specify

## HOSPITALIZATION

Type of illness or operation/procedure

Date

Hospital

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

## X-RAYS

Date

Hospital/Clinic

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

**MEDICATIONS** - List all drugs, vitamins, herbs being taken at present with dosage. (Use separate page if needed) Also list if you think these are helping are or causing any adverse effects. If applicable please list all drugs and treatments used for the current condition you are undergoing care for.

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

Are you allergic to any medications or other substances? Y N

If yes, please list \_\_\_\_\_

What happens when you have an "allergy attack"? \_\_\_\_\_



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**FAMILY HISTORY** - Please list ages and if deceased, what they died from and at what age.

Mother's Side

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Mother \_\_\_\_\_

Sisters \_\_\_\_\_

Father's Side

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Father \_\_\_\_\_

Brothers \_\_\_\_\_

Has any **Blood Relative** had any of the following:

YES NO D.K. (don't know)

\_\_\_\_\_ Anemia  
 \_\_\_\_\_ Arthritis  
 \_\_\_\_\_ Asthma  
 \_\_\_\_\_ Bleeding (easily)  
 \_\_\_\_\_ Cancer (type)  
 \_\_\_\_\_ Diabetes  
 \_\_\_\_\_ Eczema  
 \_\_\_\_\_ Glaucoma  
 \_\_\_\_\_ Gout  
 \_\_\_\_\_ Other (specify)

YES NO D.K. (don't know)

\_\_\_\_\_ Hay fever  
 \_\_\_\_\_ Heart attack  
 \_\_\_\_\_ High Blood Pressure  
 \_\_\_\_\_ Seizures/Epilepsy  
 \_\_\_\_\_ Sickle Cell Anemia  
 \_\_\_\_\_ Stroke  
 \_\_\_\_\_ Thyroid (hyper/hypo)  
 \_\_\_\_\_ Tuberculosis (TB)  
 \_\_\_\_\_ Venereal Disease  
 \_\_\_\_\_ (specific type)

**SOCIAL HISTORY:**

Do you or have you camped? \_\_\_\_\_ How long ago? \_\_\_\_\_

Have you traveled outside the U.S. in the past year? \_\_\_\_\_ Where? \_\_\_\_\_

Military Status: When did you serve? \_\_\_\_\_ Where? \_\_\_\_\_

Discharge Status \_\_\_\_\_

**HEALTH HABITS:**

Do you drink? \_\_\_\_\_ If so, what: Wine \_\_\_\_\_ Beer \_\_\_\_\_ other alcohol \_\_\_\_\_

Do you use tobacco or have you in the past? \_\_\_\_\_ If so, how much presently? \_\_\_\_\_

Total number of years smoking? \_\_\_\_\_ Total number of years since stopped smoking? \_\_\_\_\_

Do you now or have in the past used marijuana or other drugs? \_\_\_\_\_ If yes, which drugs, how often and for how long? \_\_\_\_\_

List any long term health problems that have resulted from taking these drugs \_\_\_\_\_

Do you exercise? \_\_\_\_\_ What form(s) \_\_\_\_\_

How often?(Hours/day and days/week) \_\_\_\_\_

Do you make time for rest, relaxation or prayer during the day and/or before bed? \_\_\_\_\_ How often? \_\_\_\_\_

How do you relax? \_\_\_\_\_

What are your primary interests or hobbies? \_\_\_\_\_

Circle any of the following that you do on a regular basis: Jog Swim Walk Bicycle Gardening

Yoga Breathing exercises Stretching Weight lifting Hike Other \_\_\_\_\_

**DIET**

Number of meals eaten per day: 1 2 3 more than 3

Where do you usually buy your food? \_\_\_\_\_

Who cooks the food you eat? \_\_\_\_\_



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List the primary foods **included** in your diet. \_\_\_\_\_

List the foods **excluded** from your diet. \_\_\_\_\_

List any of the following (and relative amounts) eaten regularly by you: Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods and other foods you suspect may be harmful to your health \_\_\_\_\_

List any of the foods you crave, regardless of their nutritional value (including sweets, chocolate, salty, sour, bread, rich/fatty, foods, etc.): \_\_\_\_\_

List any foods to which you have a bad reaction : \_\_\_\_\_

Are you thirsty? \_\_\_\_ Amount of fluids you drink/day: \_\_\_\_\_ Amount of water/day \_\_\_\_\_

What temperature do you prefer to drink fluids? Hot \_\_\_\_ Cold \_\_\_\_ Room temperature \_\_\_\_

Are you satisfied with your diet as it is now? \_\_\_\_ If not, why not? \_\_\_\_\_

**SLEEP** - Do you have trouble falling asleep? \_\_\_\_ If yes, what keeps you up? \_\_\_\_\_

Do you sleep straight through the night? \_\_\_\_ If not, what time do you usually wake? \_\_\_\_\_ Average number of hours you sleep \_\_\_\_\_ Do you wake refreshed? \_\_\_\_ Do you have recurrent dreams? \_\_\_\_ If yes, what is the theme \_\_\_\_\_

What position do you usually sleep in? \_\_\_\_\_ Is there a position you cannot sleep in? \_\_\_\_ If yes, which one? \_\_\_\_\_ Why? \_\_\_\_\_

## **HOME ENVIRONMENT AND OTHER ENVIRONMENTAL EXPOSURES:**

Circle any of the following you routinely use at home: Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket T.V. Distilled/Filtered/Spring/Well/Deionized/Tap water

Is your home and work environment well ventilated? \_\_\_\_\_

Is your home or work environment excessively damp or moist? \_\_\_\_\_

Please circle any of the following you feel most bothered by: Sunshine Lack of sunshine Dampness Dryness Cold Heat Seashore Mountains New Moon Full Moon Dust/Mold Cat or Dog hair Car fumes Poor air/ventilation Fluorescent lighting Chemicals (specify) \_\_\_\_\_

Spring Summer Fall Winter

Change in weather (specify) \_\_\_\_\_ Wind Thunder Rain

Other (specify) \_\_\_\_\_

Do you get outdoors daily? \_\_\_\_\_

Do you feel better outside or indoors? \_\_\_\_\_

How do you feel about your work? Do you enjoy it, are you satisfied and fulfilled by it, does it provide you with the necessities of life, is it just a job you feel you must put in the hours in order to make a living?

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



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**SYMPTOMS:** Please mark (1) = MILD, (2) = MODERATE, (3) = SEVERE

## Male Reproductive

NOW PAST

\_\_\_\_ Prostate problems  
\_\_\_\_ Swelling, lumps and pain  
in testicles  
\_\_\_\_ Discharge from penis  
\_\_\_\_ Infertility

NOW PAST

\_\_\_\_ Painful erection  
\_\_\_\_ Difficult achieving and  
maintaining erection  
\_\_\_\_ Difficult ejaculation

Are you currently sexually active? \_\_\_\_\_ Have you been sexually active in the past? \_\_\_\_\_

Type of contraception used? \_\_\_\_\_

## Female Reproductive

NOW PAST

\_\_\_\_ Lumps in breast  
\_\_\_\_ Nipple discharge  
\_\_\_\_ Breast pain  
\_\_\_\_ Pelvic pain  
\_\_\_\_ Discharge from vagina  
\_\_\_\_ Vaginal itching/burning  
\_\_\_\_ Genital eruptions  
\_\_\_\_ Type?

NOW PAST

\_\_\_\_ Painful sex  
\_\_\_\_ Lack of sexual desire  
\_\_\_\_ Difficulty feeling sexual  
arousal  
\_\_\_\_ Never/seldom have orgasms  
\_\_\_\_ Menstruation excessive  
\_\_\_\_ Menstruation absent  
\_\_\_\_ Bleed or spot between periods

Have you ever used birth control pills? \_\_\_\_\_ For how long? \_\_\_\_\_

Have you ever used an I.U.D.? \_\_\_\_\_ For how long? \_\_\_\_\_ What kind? \_\_\_\_\_

Are you currently sexually active? \_\_\_\_\_ Have you been sexually active in the past? \_\_\_\_\_

Current form/s of contraception \_\_\_\_\_

Age when menstrual periods began \_\_\_\_\_ Did you have a normal puberty? \_\_\_\_\_

Period every \_\_\_\_\_ days. Regular: Yes No

Periods usually last \_\_\_\_\_ days (average) Date of last period \_\_\_\_\_

Please put a **B** if before period, **D** if during period, or a **A** if after period:

\_\_\_\_ Abdominal cramping  
\_\_\_\_ Backache  
\_\_\_\_ Water retention  
\_\_\_\_ Breast tenderness  
\_\_\_\_ Headache/migraine  
\_\_\_\_ Depression  
\_\_\_\_ Lethargy  
\_\_\_\_ Sadness  
\_\_\_\_ Cry a lot at anything  
\_\_\_\_ Anger  
\_\_\_\_ Irritable  
\_\_\_\_ Anxiety  
\_\_\_\_ Mood changes  
\_\_\_\_ Oversensitivity  
\_\_\_\_ Want to be left alone  
\_\_\_\_ Inability to concentrate

Date of last PAP smear \_\_\_\_\_ Was it normal? \_\_\_\_\_ If not, explain \_\_\_\_\_

Do you currently, or have had in the past, problems with infertility \_\_\_\_\_ If yes, explain \_\_\_\_\_

Number of: pregnancies \_\_\_\_\_ births \_\_\_\_\_ miscarriages \_\_\_\_\_ abortions \_\_\_\_\_

Any complications of pregnancy? \_\_\_\_\_ If yes, explain \_\_\_\_\_



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## Mental Status

<u>NOW</u>	<u>PAST</u>		<u>NOW</u>	<u>PAST</u>	
___	___	Anxiety	___	___	Memory difficult, forgetful
___	___	Restlessness	___	___	Mental confusion
___	___	Excessive worry	___	___	Decreased concentration
___	___	Excessive excitement	___	___	and comprehension
___	___	Depression	___	___	Make many mistakes
___	___	Despair/Discontent	___	___	Shy, Timid
___	___	Suicidal thoughts	___	___	Critical of self
___	___	Suicidal attempts	___	___	Critical of others
___	___	Loneliness/feel alone	___	___	Lack self-confidence
___	___	Mood swings	___	___	Suspicious/jealous
___	___	Prefer to be with company	___	___	Sensitive to noise
___	___	Prefer to be left alone	___	___	Organized, neat/clean
___	___	Doesn't seek out company	___	___	Affectionate
___	___	Afraid when left alone	___	___	Assertive, powerful
___	___	Would rather be left alone	___	___	Confident, secure
___	___	when not feeling well	___	___	Intimate with others

**SELF-DESCRIPTION:** Please complete the following: Explain where possible  
 In 1 - 2 paragraphs, write a short description of yourself as you see yourself currently. Include strengths, weaknesses and major personality characteristics. (use the back of the page if necessary)

**Anger:** What makes you angry? \_\_\_\_\_  
 Do you get angry often/easily? \_\_\_\_\_  
 Do you experience uncontrollable rage? \_\_\_\_\_  
 Do you have difficulty expressing anger? \_\_\_\_\_  
 How do you express anger? \_\_\_\_\_

**Sadness:** What makes you sad? \_\_\_\_\_  
 Do you cry when sad? \_\_\_\_\_  
 Do you cry often/easily? \_\_\_\_\_  
 Would you rather be left alone? \_\_\_\_\_  
 Does being consoled help? \_\_\_\_\_

**Grief:** List major experiences of grief/loss in your life:

**Fears:** What fears do you have? Are they uncontrollable?

**Sex:** Is your present sex life satisfactory?

Are there any known episodes of physical or sexual abuse in the past?



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How many children do you have? Please list name, sex and ages. Include any details of your relationship to them that you feel is important.

Who are the most important people in your life?

What is the quality of the major relationship in your life?

How do you relate to most people?

Is Spirituality important in your life? How can your spiritual practices help you through your current or future health issues?

Is there anything about your present behavior you would like to change?

What do you feel is your major mental or emotional limitation?

What do you do for enjoyment?

Are you happy with your life presently? Why or why not?

\*\*\*Thank You For Your Cooperation, Patience and Thoroughness\*\*\*



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DIET JOURNAL for \_\_\_\_\_ BEGINNING

DATE \_\_\_\_\_

The purpose of this diary is to provide an unbiased record of your normal eating habits. Simply eat your typical diet for seven days in succession and record each meal. Wherever possible enter quantities of each food and ingredients of a complex dish. Please be totally honest with what you eat and the amounts. Under notes enter times of symptoms such as mood changes, indigestion, headaches, fatigue, etc. Under BM enter bowel movement times and any noteworthy descriptions (e.g.: loose or dry & hard; blood or mucous, etc.). Include **all** foods and drinks consumed during each day.

Supplements normally taken with amounts:

AM Day 1	Noon	PM	Notes	BM
Day 2				
Day 3				
Day 4				



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## Informed Consent Form

Name: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I acknowledge that **no** recommendations have been made to discontinue any treatment or care being provided by another health care professional.

I understand that there is **no** Guarantee or Warrantee, expressed or implied, concerning the outcome of the care provided.

Possible side effects of the therapies provided in this clinic are bleeding, bruising, discomfort, light-headedness or others as described by the physician and staff.

I acknowledge that my questions about the procedure(s) or care have been answered to my full satisfaction. This includes information regarding possible negative outcomes and what to do if difficulties are experienced.

Patient Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

(if patient under 18 years old) Date: \_\_\_\_\_

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# Visconti Acupuncture & Natural Medicine

## Doctor Correspondence

We would like to keep your primary physician informed about your treatment and progress. By signing below you are authorizing Visconti Acupuncture & Natural Medicine to correspond with your doctor by phone, fax or mail and update your Doctor about your condition and progress. This information can include progress notes, lab reports, treatment plans, reports and assessments. Thank you.

Primary Physician's

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone# \_\_\_\_\_

Fax # \_\_\_\_\_

Patient Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

DOB \_\_\_\_\_

Date \_\_\_\_\_

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# Visconti Acupuncture & Natural Medicine

## Patient Information Questionnaire

- I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

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- II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

- III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

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- IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": YES \_\_\_\_\_ NO \_\_\_\_\_

- IV. Please print the telephone number where you want to receive call about your appointments, lab and x-ray results, or other health care information if other than your home phone number: \_\_\_\_\_

- VI. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES \_\_\_\_\_ NO \_\_\_\_\_

Patient Name: \_\_\_\_\_

Guardian if under 18 years: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_