



Michael A. Visconti, AP

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 I have the better I 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.

My 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 lasting 30 minutes to 1 hour. You and I will review your history, establish your goals and decide on any further testing you may need either from my 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.

My 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 I 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 my focus is on you as a whole person and on creating a plan that will improve you body's function and self-healing ability, I 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 352-241-7581. Please send the forms back to me before your appointment if possible so I can make the most of your visit. I look forward to meeting with you.

Sincerely,

Michael A. Visconti, AP

*I schedule patients one at a time. If you need to cancel or change your appointment please give us at least 24 hours so I can schedule someone else in your time slot. A \$50 fee will be billed in case of a no show or late cancellation.

235 Citrus Tower Blvd., Clermont, FL 34711

Office: 352-241-7581 Fax: 352-241-7582

www.docvisconti.com

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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 _____	

HEALTH HISTORY

<u>NOW</u>	<u>PAST</u>	<u>NEVER</u>		<u>NOW</u>	<u>PAST</u>	<u>NEVER</u>		
_____	_____	_____	Allergies	_____	_____	_____	Injury (serious)	
_____	_____	_____	Anemia	_____	_____	_____	Kidney Disease	
_____	_____	_____	Arthritis	_____	_____	_____	Liver Ds./jaundice	
_____	_____	_____	Asthma	_____	_____	_____	Overweight	
_____	_____	_____	Alcoholism	_____	_____	_____	Pneumonia	
_____	_____	_____	Bleeding	_____	_____	_____	Polio	
_____	_____	_____	Cancer	_____	_____	_____	Rheumatism	
_____	_____	_____	Candida (yeast)	_____	_____	_____	Thyroid	
_____	_____	_____	Colitis				(Hyper/Hypo)	
_____	_____	_____	Drugs/Alcohol use*	_____	_____	_____	Tuberculosis	
_____	_____	_____	Eczema	_____	_____	_____	Venereal Disease	
_____	_____	_____	Emphysema	_____	_____	_____	Others (specify)	
_____	_____	_____	Headache	_____				
_____	_____	_____	Heart murmur*	_____				
_____	_____	_____	High Blood Pressure	_____				

(*) 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"? _____

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

<u>Mother's Side</u>	<u>Father's Side</u>
Grandfather _____	Grandfather _____
Grandmother _____	Grandmother _____
Mother _____	Father _____
Sisters _____	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? _____

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?

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

Male Reproductive

<u>NOW</u>	<u>PAST</u>		<u>NOW</u>	<u>PAST</u>	
___	___	Prostate problems	___	___	Painful erection
___	___	Swelling, lumps and pain in testicles	___	___	Difficult achieving and maintaining erection
___	___	Discharge from penis	___	___	Difficult ejaculation
___	___	Infertility			

Are you currently sexually active? _____ Have you been sexually active in the past? _____
Type of contraception used? _____

Female Reproductive

<u>NOW</u>	<u>PAST</u>		<u>NOW</u>	<u>PAST</u>	
___	___	Lumps in breast	___	___	Painful sex
___	___	Nipple discharge	___	___	Lack of sexual desire
___	___	Breast pain	___	___	Difficulty feeling sexual arousal
___	___	Pelvic pain	___	___	Never/seldom have orgasms
___	___	Discharge from vagina	___	___	Menstruation excessive
___	___	Vaginal itching/burning	___	___	Menstruation absent
___	___	Genital eruptions	___	___	Bleed or spot between periods
_____		Type?	___	___	

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	___	Cry a lot at anything
___	Backache	___	Anger
___	Water retention	___	Irritable
___	Breast tenderness	___	Anxiety
___	Headache/migraine	___	Mood changes
___	Depression	___	Oversensitivity
___	Lethargy	___	Want to be left alone
___	Sadness	___	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 _____

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?

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

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				

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: _____