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 you 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.)

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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 ___ Cohabitating ___
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 the 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 <u>childhood</u> 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		NOW	PAST	NEVER	
____	____	____	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*				(*) Please specify
____	____	____	High Blood Pressure				_____

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	Father's Side
Grandfather _____	Grandfather _____
Grandmother _____	Grandmother _____
Mother _____	Father _____
Sisters_____	Brothers_____

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

YES	NO	D.K.	(don't know)	YES	NO	D.K.	(don't know)
___	___	___	Anemia	___	___	___	Hay fever
___	___	___	Arthritis	___	___	___	Heart attack
___	___	___	Asthma	___	___	___	High Blood Pressure
___	___	___	Bleeding (easily)	___	___	___	Seizures/Epilepsy
___	___	___	Cancer (type)	___	___	___	Sickle Cell Anemia
___	___	___	Diabetes	___	___	___	Stroke
___	___	___	Eczema	___	___	___	Thyroid (hyper/hypo)
___	___	___	Glaucoma	___	___	___	Tuberculosis (TB)
___	___	___	Gout	___	___	___	Venereal Disease
_____			Other (specify)	_____			(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 <u>cannot</u> 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		NOW	PAST	
____	____	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

NOW	PAST		NOW	PAST	
____	____	Lumps in breast	____	____	Painful sex
____	____	Nipple discharge	____	____	Lack of sexual desire
____	____	Breast pain	____	____	Difficulty feeling sexual arousal
____	____	Pelvic pain			
____	____	Discharge from vagina	____	____	Never/seldom have orgasms
____	____	Vaginal itching/burning	____	____	Menstruation excessive
____	____	Genital eruptions	____	____	Menstruation absent
_____		Type?	____	____	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	_____	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 _____

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Mental Status

NOW	PAST		NOW	PAST	
____	____	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	**Noon**	**PM**	**Notes**	**BM**
Day 1				
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 Warranty, 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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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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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):

_____

_____

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.

_____

_____

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: _____