

**Patient Health History**  
**Denise Cicuto, L.Ac.**

Name: \_\_\_\_\_  
(first) (middle) (last)

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

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_ **Gender:** Male Female Transgendered Intersex Other

Marital status: S M D W

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.*

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2.. Please identify the health concerns that have brought you here today; List in order of most extreme.

*Please indicate painful of distressed areas below*

A. \_\_\_\_\_

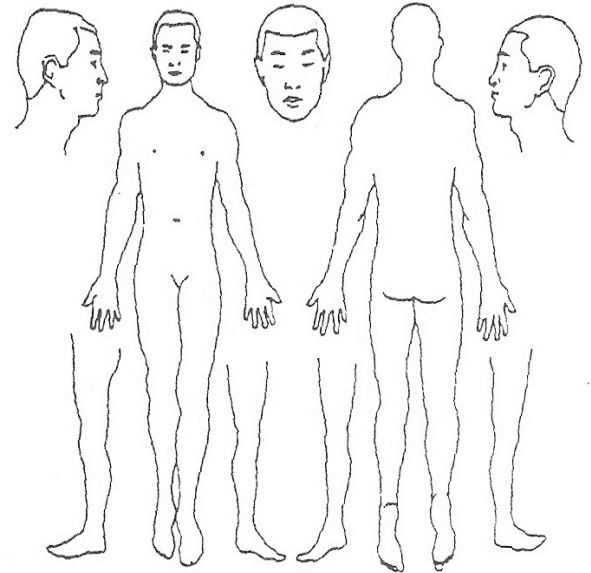
How does this condition affect you? \_\_\_\_\_

B. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

C. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_



3.. List all foods, drugs, or medications you are **hypersensitive** or allergic to  
(please include reaction): \_\_\_\_\_

4.. Please list any medications (prescribed and over-the-counter), vitamins, and  
supplements you are currently taking: \_\_\_\_\_

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

5.. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

6.. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_/\_\_\_\_ When was this reading taken? \_\_\_\_\_

7. Do you have any infectious diseases? Y N If yes, please identify: \_\_\_\_\_

8. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

9. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others: \_\_\_\_\_

**10. Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**11. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

**12. Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia          Cancer          Rashes          Eczema/Hives          Cold Hands/Feet

**13. Family History:**

Father          Mother          Brothers          Sisters          Spouse          Children

*Check those applicable:*

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

**14. Please circle if you have any of the following:**

- Cardiac pacemaker
- Seizure disorder
- Bleeding disorder
- Fainting disorder
- Believe you are or may be pregnant
- HIV
- Hepatitis B

**15. Is there anything else we should know?** \_\_\_\_\_

\_\_\_\_\_

16. Put a check mark by the symptoms that pertain to you

- |  |   |
|--|---|
| <input type="checkbox"/> cold hands / feet                         | <input type="checkbox"/> diarrhea alternating with constipation |
| <input type="checkbox"/> varicose veins                            | <input type="checkbox"/> tight feeling in the chest             |
| <input type="checkbox"/> fatigue                                   | <input type="checkbox"/> bitter taste in the mouth              |
| <input type="checkbox"/> feverish in the afternoon or hot flashes  | <input type="checkbox"/> blood shot eyes / dry eyes             |
| <input type="checkbox"/> heat sensations in the hands, feet, chest | <input type="checkbox"/> anger easily                           |
| <input type="checkbox"/> night sweating                            | <input type="checkbox"/> skin rashes                            |
| <input type="checkbox"/> catch cold easily                         | <input type="checkbox"/> headache                               |
| <input type="checkbox"/> sweat easily                              | <input type="checkbox"/> numbness of hands and feet             |
| <input type="checkbox"/> dizziness                                 | <input type="checkbox"/> muscle spasms, twitching, cramping     |
| <input type="checkbox"/> see floating black spots                  | <input type="checkbox"/> seizure / convulsions                  |

- |   |   |
|---|---|
| <input type="checkbox"/> mood swings                      | <input type="checkbox"/> sore, cold weak knees                    |
| <input type="checkbox"/> heart murmur                     | <input type="checkbox"/> low back pain                            |
| <input type="checkbox"/> high blood pressure              | <input type="checkbox"/> frequent urination                       |
| <input type="checkbox"/> palpitations                     | <input type="checkbox"/> get up more than once a night to urinate |
| <input type="checkbox"/> sores on the tip of tongue       | <input type="checkbox"/> lack of bladder control                  |
| <input type="checkbox"/> anxiety / nervousness            | <input type="checkbox"/> memory problems                          |
| <input type="checkbox"/> chest pain radiating to shoulder | <input type="checkbox"/> hair loss                                |
| <input type="checkbox"/> ankle swelling                   | <input type="checkbox"/> ringing in ears                          |
| <input type="checkbox"/> insomnia                         |   |

- |  |  |
|--|--|
| <input type="checkbox"/> cough                           | <input type="checkbox"/> slow healing wounds                           |
| <input type="checkbox"/> sinus congestion / pressure     | <input type="checkbox"/> TMJ / grinding teeth                          |
| <input type="checkbox"/> dry mouth, throat, nose or skin | <input type="checkbox"/> shortness of breath (inhale or exhale)        |
| <input type="checkbox"/> allergies / hay fever           | <input type="checkbox"/> low appetite                                  |
| <input type="checkbox"/> chronic infections              | <input type="checkbox"/> loose stools                                  |
| <input type="checkbox"/> asthma                          | <input type="checkbox"/> constipation                                  |
| <input type="checkbox"/> frequent sore throats           | <input type="checkbox"/> abdominal bloating or gas after eating        |
| <input type="checkbox"/> chills with alternation fever   | <input type="checkbox"/> feeling tired after eating                    |
| <input type="checkbox"/> stiff neck / shoulders          | <input type="checkbox"/> prolapsed organs (previously diagnosed)       |
| <input type="checkbox"/> difficult breathing             | <input type="checkbox"/> bruise easily                                 |
|  | <input type="checkbox"/> general feeling of heaviness in the body      |
|  | <input type="checkbox"/> mental sluggishness/ forgetfulness/exhaustion |
|  | <input type="checkbox"/> swollen hands / feet                          |
|  | <input type="checkbox"/> burning sensation after eating                |
|  | <input type="checkbox"/> large appetite                                |
|  | <input type="checkbox"/> bad breath                                    |
|  | <input type="checkbox"/> mouth sores (canker sores)                    |
|  | <input type="checkbox"/> bleeding, swollen painful gums                |
|  | <input type="checkbox"/> heartburn / belching                          |
|  | <input type="checkbox"/> hemorrhoids                                   |
|  | <input type="checkbox"/> stomach pain / stomach ulcer                  |
|  | <input type="checkbox"/> vomiting                                      |

Urination is:

- normal color (pale yellow)
- clear
- dark yellow
- reddish
- cloudy
- scanty
- has odor
- burning
- painful
- difficult
- urgent
- history of urinary tract infections

Libido (sex drive)    Normal    --    Low    --    High

**Men Only**

*Please put a check mark by the symptoms that pertain to you.*

- Feeling of coldness or numbness in the external genitalia
- pain of swelling of testicles
- premature ejaculation
- impotence / erectile dysfunction

**Women Only**

*Please answer each question or check the appropriate response.*

- A Are you currently pregnant now?                       yes       no
- B Number of children:
- C Number of pregnancies:
- D Age of first period:
- E Menstrual Cycle

Average number of days of flow:

The flow is: **normal, heavy, light**

The color is: **normal, dark, purple, light brown, brown, bright red, light red / pink**  
(circle as many that apply)

*Please answer each question or check the appropriate response.*

- menopausal symptoms (age of menopause if applicable)
- Premenopausal symptoms
- irregular cycle
- vaginal discharge
- nipple discharge
- heavy flow
- bleeding between cycles
- painful periods
- clotting
- premenstrual symptoms (PMS)
- breast lumps / tenderness
- difficulty conceiving

*Please include any additional information related to your menstrual cycle in the space below:*

**17. Lifestyle:**

- a. Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_
- b. Exercise routine: \_\_\_\_\_
- c. Spiritual practice: \_\_\_\_\_
- d. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N
- e. Level of education completed:      High School      Bachelors      Masters      Doctorate      Other
- f. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_  
Do you enjoy work?    Y/N    Why/Why not? \_\_\_\_\_
- g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_
- h. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_  
\_\_\_\_\_
- i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_
- j. Television habits: \_\_\_\_\_      Reading habits: \_\_\_\_\_
- k. Interests and hobbies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- l. If there was one thing you could do, make, or create... given all the resources you needed to succeed ... what would it be / what would you do? \_\_\_\_\_

Name:			
Address:			
City:		State:	Zip Code
Home Phone:		Cell / Work Phone:	
Email:			
SS#			
Spouse's Name			
Emergency Contact		Tele #	
Occupation:			
Employers Address:			
Medical Insurance::		Group Number:	
Medical Doctor:		Chiropractor:	
Other healthcare provider:			

## PATIENT AGREEMENT

### TO ALL NEW PATIENTS:

Welcome to our office. We hope that you find our office and staff pleasant. We are here to serve you, so please feel free to speak with us about any concerns you may have.

### CANCELING OR CHANGING APPOINTMENTS:

All appointments must be cancelled **24 hours in advance** or there will be a \$25.00 charge for your missed appointment. If you need to change or cancel an appointment, be sure to make up the missed appointment.

### FEES:

Fees for services are expected to be paid at the time of each visit, unless you are on a lien. For your convenience, we accept cash, personal checks, and most credit cards.

We do not take insurance. As a courtesy, our office is set-up to give you a 'superbill' for your insurance needs. You will then have to submit it directly to your insurance company to receive your payments.

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Patient's Signature

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Date

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Please print name above