CICUTO ACUPUNCTURE

Denise Cicuto

PATIENT HEALTH HISTORY

Please fill out and print.

Bring with you to your appointment. Note: If you are viewing through Adobe Reader, there is no option to save, you must print.

Name: _____ _____ _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Preferred name: _____ **Preferred pronouns:** _____

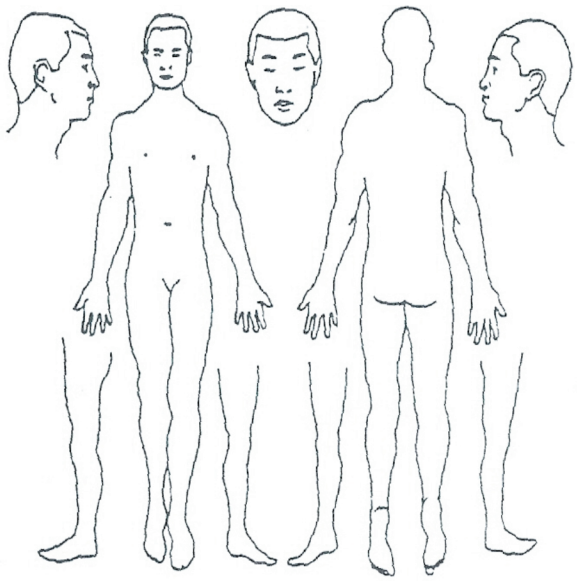
Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question 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 check any that you have had):

☐ Polio ☐ Tetanus ☐ Rubella/Mumps/Rubella ☐ Pertussis ☐ Diphtheria ☐ Hepatitis B

Others: _____

10.. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

12. **Other** (please check 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:** *Check those applicable:*	Father	Mother	Brothers	Sisters	Spouse	Children
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 check 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**

- ☐ cold hands / feet
- ☐ varicose veins
- ☐ fatigue
- ☐ feverish in the afternoon or hot flashes
- ☐ heat sensations in the hands, feet, chest
- ☐ night sweating
- ☐ catch cold easily
- ☐ sweat easily
- ☐ dizziness
- ☐ see floating black spots

- ☐ diarrhea alternating with constipation
- ☐ tight feeling in the chest
- ☐ bitter taste in the mouth
- ☐ blood shot eyes / dry eyes
- ☐ anger easily
- ☐ skin rashes
- ☐ headache
- ☐ numbness of hands and feet
- ☐ muscle spasms, twitching, cramping
- ☐ seizure / convulsions

- ☐ mood swings
- ☐ heart murmur
- ☐ high blood pressure
- ☐ palpitations
- ☐ sores on the tip of tongue
- ☐ anxiety / nervousness
- ☐ chest pain radiating to shoulder
- ☐ ankle swelling
- ☐ insomnia

- ☐ sore, cold weak knees
- ☐ low back pain
- ☐ frequent urination
- ☐ get up more than once a night to urinate
- ☐ lack of bladder control
- ☐ memory problems
- ☐ hair loss
- ☐ ringing in ears

- ☐ cough
- ☐ sinus congestion / pressure
- ☐ dry mouth, throat, nose or skin
- ☐ allergies / hay fever
- ☐ chronic infections
- ☐ asthma
- ☐ frequent sore throats
- ☐ chills with alternation fever
- ☐ stiff neck / shoulders
- ☐ difficult breathing

Urination is:

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

- ☐ slow healing wounds
- ☐ TMJ / grinding teeth
- ☐ shortness of breath (inhale or exhale)
- ☐ low appetite
- ☐ loose stools
- ☐ constipation
- ☐ abdominal bloating or gas after eating
- ☐ feeling tired after eating
- ☐ prolapsed organs (previously diagnosed)
- ☐ bruise easily
- ☐ general feeling of heaviness in the body
- ☐ mental sluggishness/ forgetfulness/exhaustion
- ☐ swollen hands / feet
- ☐ burning sensation after eating
- ☐ large appetite
- ☐ bad breath
- ☐ mouth sores (canker sores)
- ☐ bleeding, swollen painful gums
- ☐ heartburn / belching
- ☐ hemorrhoids
- ☐ stomach pain / stomach ulcer
- ☐ vomiting

Libido (sex drive) ☐ Normal ☐ Low ☐ High

Sexual and reproductive health:

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

A Are your 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)
☐ chest 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: _____

How did you hear about us? _____

_____

Emergency contact relationship:_____ Emergency Contact: _____ Tele #_____

Occupation: _____

Employer's Address: _____

Medical Insurance: _____

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 $120 charge for your missed appointment. If you need to change or cancel an appointment, be sure to make up the missed appointment.

Please note: The only exception for late cancellations is if you are experiencing any COVID symptoms or have been exposed to anyone who is positive for COVID-19.

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 'superbilll' for your insurance needs. You will then have to submit it directly to your insurance company to receive your payments.

_____ _____

Patient's Signature Date

_____

Please print name above