Christy Vitiello acupuncture

Christy Vitiello, L.AC.
1489 Webster Street, Suite 206, San Francisco, CA 94115

Health History

Today's Date: _____

Name: _____

Street: _____

City: _____

State: _____

Zip Code: _____

E-Mail: _____

Phone: _____

Referred by: _____

Date of Birth: _____

Age: _____ Gender: _____

Weight: _____ Height: _____

Emergency Contact

Emergency Contact Name: _____

Emergency Contact Ph: _____

Relation to you: _____

Employment

Your Occupation: _____

Your Employer: _____

Insurance Info

Insurance Company: _____

Insurance ID or Member #: _____

Provider Phone [back of card]: _____

Insured Name and DOB if not you: _____ _____

Assignment & Release

I hereby assign my insurance benefits to be paid directly to the provider for service. I understand that I am financially responsible for any non-covered services. I also authorize Christy Vitiello to release any information required to process claims.

Signed Date

Please identify the health history concerns that you would like us to help you with in order of importance

1. _____ When did the problem begin? _____

Medical diagnosis: _____

How does this condition interfere with daily activities such as work, sleep, etc.?

_____

What types of treatment have you tried? _____

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2. _____ When did the problem begin? _____

Medical diagnosis: _____

How does this condition interfere with daily activities such as work, sleep, etc.?

_____

What types of treatment have you tried? _____

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3. _____ When did the problem begin? _____

Medical diagnosis: _____

How does this condition interfere with daily activities such as work, sleep, etc.?

_____

What types of treatment have you tried? _____

Lifestyle

How many meals per day do you typically eat?

Please describe your typical breakfast, lunch, dinner, and snacks:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many glasses of water per day do you typically drink? _____

How many cups of caffeinated coffee/tea/soda do you drink each day? _____

How many alcoholic beverages do you drink per week? _____

Do you use any prescription or non-prescription drugs recreationally? _____

How often do you exercise? _____

Please describe your exercise routine: _____

For each of the conditions listed below, place a check in the ***Past*** column if you had the condition in the past.
If you presently have a conition listed below, place a check in the ***Present*** column

Past	Present	
☐	☐	General Fatigue
☐	☐	Muscular Incordination
☐	☐	Visual Disturbances
☐	☐	Dizziness
☐	☐	Thyroid Problems
☐	☐	Allergies

Past	Present	
☐	☐	Chronic Sinusitis
☐	☐	Asthma
☐	☐	Lung Disease
☐	☐	Nosebleeds
☐	☐	Bad Breath

Past	Present	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Panic Attacks
☐	☐	Thoughts of Suicide
☐	☐	Anger
☐	☐	Mood Swings

☐	☐	Low Blood Pressure
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Swollen Hands/Ankles/Feet
☐	☐	Family Heart Disease

☐	☐	Loss of Hair
☐	☐	Dandruff
☐	☐	Hives
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Rashes
☐	☐	Pimples

☐	☐	Systemic Lupus
☐	☐	Rheumatoid Arthritis
☐	☐	Epilepsy
☐	☐	Other Nerve Disorders
☐	☐	HIV/AIDS
☐	☐	Cancer
☐	☐	Sexually Transmitted Diseases

☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Frequent UTI

☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Mono

☐	☐	Coffee Drinker
☐	☐	Acid Reflex

☐	☐	Abdominal Weight Gain
☐	☐	Loss of Appetite Nausea
☐	☐	Vomiting Abdominal Pain
☐	☐	Ulcer
☐	☐	Black Stools
☐	☐	Pancreatitis
☐	☐	Irritable Bowel Syndrome
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Hemorroids
☐	☐	Rectal Pain/Itching
☐	☐	Hepatitis

Type: ____

☐	☐	Smoking/Tobacco Use
☐	☐	Drug/Alcohol Dependence

☐	☐	Botox
☐	☐	Pacemaker
☐	☐	Metal Implants

Men Only

☐	☐	Prostrate Problems
☐	☐	Erectile Dysfunction
☐	☐	Testicular Pain/Swelling

Women Only

☐	☐	Birth Control
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	Miscarriages
☐	☐	Menopausal Symptoms
☐	☐	Irregular Cycles
☐	☐	Painful Periods
☐	☐	Bleeding Between Cycles
☐	☐	Infertility

List all prescriptions and over-the-counter **medications** you are taking and the reasons for taking them

List all **nutritional/herbal supplements** you are taking

List any food, drugs, medicines, or substances to which you are hypersensitive or **ALLERGIC**

List all **surgical procedures, hospitalizations, major accidents, major illnesses** you have had

List any **diseases/conditions** that an immediate family member has had

Mark each box where you feel pain or distress