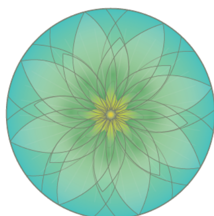

NAME:________________________________ DATE:____________

ADDRESS:____

PHONE:_________________________ _____________________________
home/cell work

EMAIL:____

EMERGENCY CONTACT:______________________ ___________________
name phone

PRIMARY PHYSICIAN:_________________________ ___________________
name phone

HEALTH INSURANCE#:____
HEALTH INSURANCE PHONE#:____
CAR ACCIDENT CLAIM#:____

HOW DID YOU HEAR ABOUT US?______________________________________

May we call you? Y N Only at Home/Cell/Work
May we send you mail? Y N May we email you? Y N

FINANCIAL POLICY

I am committed to providing you with excellent and affordable health care. Payment for services and products (supplements/herbs) is due at the time of your appointment.

There is a 24-hour cancellation or rescheduling policy for all appointments. If you need to reschedule your appointment less than 24-hours ahead, or if you miss your appointment, you will be charged the regular fee.

All payments can be made directly to Annmarie Ritacca in form of Cash, Check, Debit or Credit Card. If you have an insurance carrier that will reimburse for acupuncture, you will be provided with a receipt referred to as a Superbill that can be submitted to your insurance company for reimbursement.

Signature:____

PATIENT HEALTH HISTORY FORM

DATE:___________________

WHAT ARE YOUR PRIMARY CONCERNS FOR TREATMENT?

1.

3.

2.

4.

OTHER TREATMENT MODALITIES YOU HAVE TRIED OR CURRENTLY USE TO TREAT YOUR CONDITIONS.

CURRENT PRESCRIPTION MEDICATIONS(Please indicate how long you have been taking them)

CURRENT OVER THE COUNTER DRUGS, SUPPLEMENTS, HERBS, VITAMINS(Please indicate how long you have been taking them)

DO YOU HAVE A PACEMAKER?	YES	NO
DO YOU HAVE REASON TO BELIEVE YOU ARE PREGNANT?	YES	NO
DO YOU HAVE A CLOTTING DISEASE OR DISFUNCTION?	YES	NO
DO YOU HAVE A CHRONIC INFECTIOUS DISEASE?	YES	NO
DO YOU HAVE A HISTORY OF ANOREXIA NERVOSA?	YES	NO

TYPICAL DAILY DIET

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

ALLERGIES

Environmental:

Foods:

Medications:

ANY HISTORY OF:

Chronic/Severe Illness?

____

____

____

Injuries or Surgeries?

____

____

____

PLEASE CHECK ALL THAT APPLY
IF A PAST CONDITION, PLEASE INDICATE WHEN?

SKIN AND CIRCULATION	Current	Past	RESPIRATORY SYSTEM	Current	Past
Rash			Pneumonia		
Acne, Boils			Frequent Common Colds		
Eczema			Difficulty Breathing		
Hives			Emphysema		
Psoriasis			Persistent Cough		
Itching			Pleurisy		
Acute Hair Loss			Asthma		
Nail Fungus			Tuberculosis		
Cold Hands/Feet			Shortness of Breath		
			Nasal Drainage		
			Spitting Up Blood		

HEAD/EENT	Current	Past		Current	Past
Glasses/Contacts			Eye Pain/Strain		
Impaired Vision			Color Blindness		
Glaucoma			Cataracts		
Tearing/Dryness			Headaches		
Spots in Front of Eyes			Migraines		
Double vision			Head Injury		
Ear Ringing			Oral Thrush		
Impaired Hearing			Gum Disease		
Earaches			Dry Mouth		
Dizziness			Hoarseness		
Sinus Problems			Teeth Grinding		
Hay Fever			TMJ Jaw Problems		
Loss of Smell			Goiter/Swollen Glands		
Loss of Taste			Frequent Sore Throats		
Oral Sores			Trouble Swallowing		

EMOTIONAL	Current	Past	NEUROLOGIC	Current	Past
Mood Swings			Vertigo/Dizziness		
Depression			Paralysis		

Anxiety			Numbness/Tingling		
Considered or Attempted Suicide			Loss of Balance		
Irritability			Seizures/Epilepsy		
Unemotional					

Musculoskeletal	Current	Past	Genito-Urinary	Current	Past
Trauma or Injury					
Neck/Shoulder Pain			Kindey Disease		
Upper Back Pain			Urinary Tract Infections		
Mid Back Pain			Painful Urination		
Low Back Pain			Frequent Urination		
Leg Pain			Night Urination		
Joint Pain			Imparied Urination		
Spasms Cramps			Dribbling/Incontinence		
Sprains or Strains			Blood in Urine		
Joint Surgeries			Kidney Stones		
			STD's		

Cardiovascular	Curre	Past	Digestion	Current	Past
Heart Disease			Nausea		
Chest Pain			Vomiting		
Ankle Swelling			Loss of Appetite		
High Blood Pressure			Gas or Bloating		
Palpitations			Ulcer		
Stroke			Heartburn		
Heart Murmurs			Abdominal Cramping		
Rheumatic Fever			Diarrhea		
Varicose Veins			Constipation		
Fainting			Hemorrhoids		
Endocarditis			Blood or Mucous in Stool		
Phlebitis			Gallstones		

Endocrine	Current	Past	Immunity	Current	Past
Hypothyroid			Fatigue		
Hyperthyroid			Slow Wound Healing		
Hypoglycemia			Chronic Infections/		

Diabetes					
Night Sweats					
Hot/Cold Sensations					
Women's Health	Current	Past	**Women's Health**	Current	Past
Irregular Cycles			Age at First Menses		
Amenorrhea(no period)			Length of Cycle		
PMS			Duration of Cycle		
Cramping			# of Pregnancies		
Heavy Flow			# of Miscarriages		
Bleeding Between Cycles			# of Abortions		
Vaginal Discharge			# of Live Births		
Breast Lumps/Tenderness					
Women's Health	Current	Past	**Men's Health**	Current	Past
Menopause			Testicular Pain		
Age of Menopause			Prostate Disease or Cancer		
Polycystic Ovaries			Penile Discharge		
Uterine Fibroids			Impotency		
Endometriosis			Infertitlity Low Sperm Count		
Infertility			STD'S		
STD's					

SIGNATURE ______________________________ DATE______________