NaturalMED THERAPIES

Patient Biographical Information

Address Information

Please print your information in the following spaces.

Name _____ Date _____

Occupation _____ Gender M ____ F____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Date of Birth _____ Cell Phone _____

SSN _____-_____-_____ E-Mail Address _____

Marital Status _____

Number of Children _____

Who is responsible for this account? _____

Home Address _____

City _____ State _____ Zip _____

How did you find us?

_____

_____

_____

Explanation of Treatment

Your treatment may include Acupuncture, Herbology, Tui Na Massage, Cupping, Moxibustion, Laser Therapy, and/or Injection Therapy, which may include Prolotherapy or Mesotherapy. Traditional Chinese Medicine is different from Western Medicine since your treatment is based on you as a whole and not by one disease or symptom. Therefore, all treatments vary due to the patient's signs and symptoms. During an Acupuncture treatment it is possible to feel cramping, heaviness, tingling, or electric sensation either around the needle or traveling up or down the affected meridian. The sensation lasts only for a few seconds and to most people it is not found to be painful. In rare cases if a patient has not eaten or is extremely nervous they may experience dizziness, nausea, cold sweat, shortness of breath, of faintness during the treatment. In many cases the patient doesn't feel the needle at all since they are as thin as hair.

After an acupuncture treatment, you may have complete symptom relief. In most cases, it takes several treatments to treat the symptoms. In rare cases when being treated for pain the symptoms can exceed the initial threshold. In these cases, the pain usually diminishes within a few hours with symptom free days that follow. You may note a spot of blood at one or more of the needle sits and/or a small bruise could develop. Overall, you should feel more relaxed and/or have more energy after a treatment.

A Cupping treatment could be advised for some patients that have pain or have a weak immune system. This treatment will leave red marks on the skin that can turn into bruises. The marks can last a few hours to a few days.

Herbs will be prescribed in most cases. The herbal formulas are formulated in most cases to fit the patient's signs and symptoms. It can take up to a couple of months before a patient can see results. Some herbal formulas in just a few minutes one can feel relief from symptoms. Since herbs are natural, it is rare to have side-effects from the herbal formula. Your Acupuncture Physician will tell you if there is any known side-effects that could be expected with the formula prescribed.

Cancellation Policy : APPOINTMENTS MUST BE CANCELLED WITHIN A 48 HOUR NOTICE (*of your appointment*) otherwise the Second Cancellation/No Show will incur a $45.00 cancellation fee . Then there will be a $100.00 fee thereafter. All fees have to be paid prior to the next scheduled visit.

Sign to received treatment as explained above _____

7600 Bryan Dairy Road, Ste C, Largo, FL 33777 Office: 727-541-2211 Fax: 727-541-2210

Patient History

Patient Name _____ DOB _____ Age _____

What health problem has brought you here today?

_____

This problem was found by: ☐ Self ☐ Doctor ☐ Screening Test

What concerns you most about this problem?

_____

Are there any factors you feel may contribute to this problem?

_____

What are you hoping to learn from this visit?

_____

Who are your primary health care providers?

Primary Care Physician _____

Specialty Physicians _____

Other Providers _____

Do you participate in regular health screenings? ☐ Yes ☐ No

If so, please indicate the month/year of those that apply:

_____ Breast Self Exam _____ Last Mammogram _____ Pelvic PAP

_____ PSA/Rectal Exam _____ Colorectal Exam _____ Testicular

_____ Blood Lab _____ Oral Dentist _____ Skin

_____ Other (please specify) _____

Pain

Do you have pain? ☐ Yes ☐ No

Rate you pain intensity at its worst on a scale of 1 to 10 where 10 is most intense:

1	2	3	4	5	6	7	8	9	10

Please indicate which words describe your pain:

☐ Piercing ☐ Dull Ache ☐ Constant ☐ Shooting

☐ Stinging/Burning ☐ Cramping ☐ Pins/Needles

☐ Other _____

What are you doing to decrease your pain? _____

Medication	Dose	Frequency	Times/24 hr

Other measures? _____

Rate pain intensity after obtaining relief measures?

1	2	3	4	5	6	7	8	9	10

Onset ☐ Rapid ☐ Gradual

Quality ☐ Dull ☐ Burning ☐ Sharp ☐ Heavy

Location ☐ Joint ☐ Muscle ☐ Low-Back ☐ Under Ribs ☐ Fixed
☐ Moving ☐ Radiating

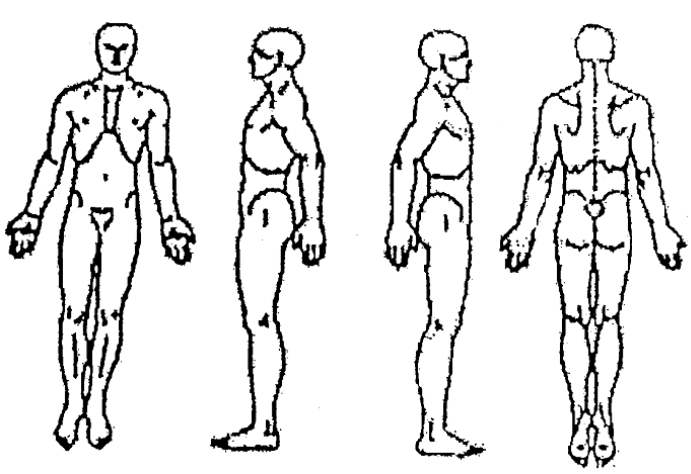
Headache Location ☐ Side ☐ Top ☐ Frontal ☐ Occipital

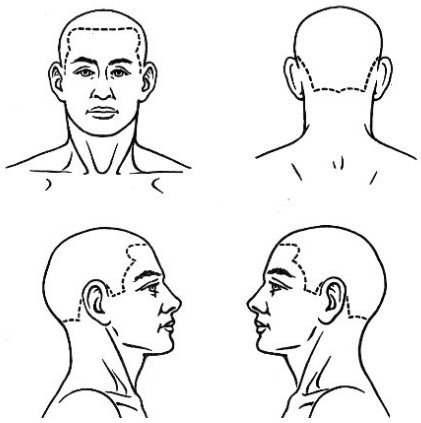
Frequency ☐ Daily ☐ Weekly x _____

Rate the severity of the pain. Circle the box using the scale below:

1	2	3	4	5	6	7	8	9	10
Almost no pain	----------				---				***Unbearable***

Indicate Location of Condition:





Lifestyle Habits

☐ Alcohol ☐ Marijuana ☐ Stress ☐ Tobacco ☐ Drugs

☐ Other _____

☐ Occupational Hazards _____

Exercise Type _____

List Surgeries	Major Trauma

Past Medical History: Mark conditions you have had with an "X" circle those you currently have.

☐ Accidents	☐ Depression	☐ Low Blood Pressure	☐ Seizures
☐ AIDS/HIV	☐ Diabetes	☐ Lupus	☐ Stroke
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Thyroid Disease
☐ Allergies	☐ Epilepsy	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Anxiety	☐ Glaucoma	☐ Mumps	☐ Typhoid Fever
☐ Appendicitis	☐ Goiter	☐ Pacemaker	☐ Ulcers
☐ Arteriosclerosis	☐ Gout	☐ Pleurisy	☐ Varicose Veins
☐ Arthritis	☐ Heart Disease	☐ Pneumonia	☐ Venereal Disease
☐ Asthma	☐ Hepatitis	☐ Polio	☐ Whooping Cough
☐ Cancer	☐ Herpes	☐ Prostate Disease	☐ Fibromyalgia
☐ Carpal Tunnel	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Other (please specify)
☐ Chicken Pox	☐ Irritable Bowels	☐ Scarlet Fever	_____

Family Medical History: Mark conditions you have had with an "X" circle those you currently have.

☐ Arteriosclerosis	☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disease
☐ Asthma	☐ Depression	☐ Seizures	
☐ Alcoholism	☐ Diabetes	☐ Stroke	

Review of Systems

Lung

Perspiration	☐ Scant	☐ Profuse	☐ Daytime	☐ Nighttime
	☐ Upper body	☐ Lower Body	☐ Spontaneous	☐ Other _____
Nose	☐ Stuffy	☐ Congested	Dry	☐ Sinus infections
	☐ Shortness of Breath	☐ Difficulty Inhaling	☐ Nosebleeds	☐ Sneezing
	☐ Difficulty breathing while lying down	☐ Difficulty Exhaling	☐ Wheezing	☐ Frequent Cold/Flu
Emotions	☐ Recent loss or long-term grief	☐ Waking 3-5 am	☐ Sadness	
Cough	☐ Dry	☐ Productive	☐ Hacking	☐ Non-Productive
Sputum	☐ Clear	☐ White Amount _____	☐ Blood tinged	☐ Yellow
	☐ Rusty	☐ Copious	☐ Scant	☐ Difficulty Raising
	☐ Green			
Skin	☐ Dry	☐ Itchy	☐ Rashes	☐ Dandruff
	☐ Body Hair loss	☐ Moist	☐ Psoriasis	☐ Fungal Infections
	☐ Eczema	☐ Acne		

Kidney/Urinary Bladder

Urine	☐ Light	☐ Dark	☐ Clear	☐ Cloudy	
	☐ Bloody	☐ Sand or Grit	☐ Sweet Odor		
Frequency	___/day	___/night	☐ Urgency	☐ Painful	☐ Weak Flow
Amount	☐ Incontinence	☐ Intermittent	☐ Intake & Output	☐ Hesitancy	☐ Dribble
Pain	☐ Low Back	☐ Weak Knees	☐ Cold Feet	☐ Worse a.m.	☐ Worse p.m.
Nose	☐ Stuffy	☐ Congested	☐ Dry	☐ Sinus infections	
	☐ Shortness of Breath	☐ Difficulty Inhaling	☐ Nosebleeds	☐ Sneezing	
	☐ Difficulty breathing while lying down	☐ Difficulty Exhaling	☐ Wheezing	☐ Frequent Cold/Flu	
Sexual Desire	☐ Low	☐ High	☐ Impotence	☐ Premature Ejaculation	
Hearing	☐ Hearing Loss	☐ Dizziness	☐ Vertigo	☐ Tinnitus	
Energy	☐ Lack of Stamina	☐ Need lots of Sleep			
Emotions	☐ Fear	☐ Disgruntled	☐ Easily Defeated	☐ Reduced Motivation	
Hair	☐ Loss/thinning	☐ Dry	☐ Premature Gray		

Liver

Eyes	☐ Vision Changes	☐ Blurred Vision	☐ Night Blindness	☐ Gritty
	☐ Floaters	☐ Watery	☐ Dry	☐ Bitter taste in mouth
	☐ Vertex Headache	☐ Pressure	☐ Painful	☐ Itchy
Pain	☐ Seizures	☐ Pain in Ribs, Groin, Pelvis	☐ Muscle Cramps/Spasms	☐ Tremors, Shaking
	☐ Nausea from Hunger	☐ Tension/pain in shoulders/neck	☐ Testicular Pain	☐ Hard, Dry stools
	☐ Brittle hair/nails	☐ Hernia		
Emotion	☐ Irritable	☐ Sensation of something in throat	☐ Loud Ringing in Ears	☐ Tics
	☐ Depression	☐ Sensitive to Noise/wind	☐ Frequent Sighing or Yawning	☐ Weak/Dizzy/Flushed from Tension/Hunger

Heart

☐ Palpitations	☐ Dizziness	☐ Dream/Disturbed Sleep	☐ Tongue Ulcers
☐ Easily Confused	☐ Lack of Focus	☐ Easily Overheats/Chills	☐ Insomnia
☐ Hard to Fall Asleep	☐ Irregular Heartbeat	☐ Slight exertion causes heat	☐ Anxiety
☐ Difficult to Stay Asleep	☐ Restless	☐ Swelling of Hands/Feet	☐ Fainting

☐ Chest Pain	☐ Poor Memory	☐ Shortness of Breath	☐ Hot Flashes
☐ Mania/Delirium	☐ Mood Swings		

Gastrointestinal Stomach/Spleen

Mouth	☐ Bleeding Gums ☐ Bad Breath	☐ Sour Regurgitation ☐ Root Canals x ____		☐ Tooth Pain ☐ Silver/Gold Fillings	☐ Dry Mouth ☐ Drooling
Appetite	☐ Poor ☐ Always Hungry	☐ Fatigue after meals ☐ Hungry after meals		☐ Weight Gain ☐ Weight Loss	☐ Hungry with no desire to eat
Cravings	☐ Bitter	☐ Bland	☐ Sweet	☐ Sour	☐ Salty
Thirst	☐ Room Temp.	☐ Cold	☐ Hot	☐ No Relief with Drinks	☐ Hungry with no desire to eat
Fluids/ Nutrition	☐ Edema	*Heavy Feelings in:*	☐ Body	☐ Head	☐ Limbs
Digestion	☐ Gas ☐ Nausea/Vomiting	☐ Belching ☐ Slow Digestion	☐ Bloating ☐ Acid Regurgitation	☐ Abdominal Distention ☐ Indigestion	☐ Cramps
Pain	Location: _____	☐ Worse after eating		☐ Better with Food	☐ Stress Induced
Bowels	Bowel Movements: ____/day; ____/week When: _____ ☐ Change in pattern ☐ Brown ☐ Mucus ☐ Hemorrhoids ☐ Blood	☐ Constipation ☐ Black ☐ Undigested Food ☐ Anal Itching		☐ Diarrhea ☐ Coffee Grounds ☐ Foul Odor ☐ Sticky/Pasty	☐ Anal Burning ☐ Unfinished Feeling ☐ Hard ☐ Urgency
Emotions	☐ Easily Worried ☐ Easily Angered	☐ Over thinking ☐ Overwhelmed by details		☐ Upset by change	☐ Melancholy

Gynecology and Pregnancy

Background	___ Age Mensus Began ___ Days of Cycle	___ Flow Duration ___ # Live Births	___ # Miscarriages ___# Pregnancies	___ # Abortions
Background	Date of Last Period _____ ☐ Early menstrual cycle (≤21 days)	Are you/Could you be pregnant? ☐ Yes ☐ No ☐ Late Menstrual Cycle (≥ 35 days)		Method of Conception _____ ☐ Irregular Menstrual Cycle
Flow	☐ Light ☐ Moderate ☐ Heavy	Color: ☐ Light Red ☐ Bright Red ☐ Dark Red	☐ Purple ☐ Brown	
Clots	☐ Small	☐ Large	☐ Many	☐ Few ☐ Dark

Cramps	☐ Before	☐ During	☐ After	☐ Breast Soreness

Vaginal Discharge	☐ Odor	☐ White	☐ Yellow	☐ Bloody
	☐ No Odor	☐ Clear		
Menopause	___ Age at Menopause	☐ Hot Flashes	☐ Night Sweats	☐ Melancholy
	☐ Menopausal Signs:	☐ Post-Menopausal	☐ Mood Swings	☐ Forgetful
Gynecology History	☐ Ovarian Cysts	☐ PID	☐ Infertility	☐ Uterine Prolapse
	☐ Painful Intercourse	☐ Vaginal Dryness	☐ Vaginal Burn/itch	☐ Venereal Disease
	☐ Vaginal Sores	☐ Fibroids	Date last PAP: _____	

Gynecology and Pregnancy (*continued)*

Urinary/Reproductive

	Present	Past	Resolved
Enlarged Prostate	☐	☐	☐
Problems with Erection	☐	☐	☐
Frequent Urination	☐	☐	☐
Trouble starting to Urinate	☐	☐	☐
Weak or Decreased Stream	☐	☐	☐
Burning or Urination	☐	☐	☐
Urinate during night number of times	☐	☐	☐
Blood or Urine	☐	☐	☐
No Control Over Urination	☐	☐	☐
Urgent Urination	☐	☐	☐
Kidney Problems	☐	☐	☐
Catheter (Type ____)	☐	☐	☐
Sexually Active ☐ Yes ☐ No	☐	☐	☐