Patient Intake Instructions

Please read and fill out the following intake and policy forms in full and bring them with you to your appointment. **Please note** If you are unable to fill out your paperwork prior to your appointment time, you must arrive 30 minutes early, or your appointment will be rescheduled for a later date.

The office is located at:
1540 International Pkwy.
Suite #2000
Lake Mary, FL 32746
407-328-6711
The building is located at the corner of 46A and International Pkwy., between the Wells Fargo and Walgreens. Take the elevator to the second floor and take an immediate right to reach the reception area. Check in with the receptionist and I will be with you shortly.

To prepare for your first acupuncture session, please dress comfortably if possible, and have a light snack within 2 hours of your visit. If you are also having a nutritional testing session, please stop taking all vitamins and herbal supplements at least 24 hours prior to your appointment time.

To prepare for your QRA session (nutritional testing) and for any follow up sessions, please trim or file fingernails down for more comfort, and for the most accurate results. Also, stop taking all vitamins and herbal supplements at least 24 hours prior to your appointment time. This will allow for the most accurate feedback as to how your organs and glands are functioning without extra nutritional support.

Insurance Policy

Many holistic treatments such as acupuncture, electro-stim, infrared therapy, office consultations and exams may be covered by your insurance. Because your insurance policy is a contract solely between you and your insurance company, it is important that you contact them directly to determine if you have coverage for these treatments. Please understand that you, the patient, are fully responsible for the fees associated with your treatments, even if your insurance company had previously agreed to pay for the treatments, either partially or in full. Forms will be provided for you to send to your insurance company, so that you will be reimbursed directly by your insurance company according to the agreement you have made with them as their customer.

I have read and acknowledge the above insurance policy:

Name _________________________________ Date: __________________
Signed
Central Florida Preventive Medicine
Patient Intake Form

Name ______________________________________ Date ________________

Address _______________________________________________________________________
_____________________________________________________________________________

Home phone __________________________ Work Phone _________________________
Cell Phone ___________________________ Email ________________________________
Occupation __________________________ Birth Date __________________________
Height _______ Weight _______

Emergency contact
____________________________________________________________________________
(name & phone)

Referred by _____________________________________________________________________
___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed ___
___ Caregiver for dependent ___ Children ________

Have you ever had acupuncture? _______ If yes, when? _________________________
Have you ever had nutrition therapy? _____ If yes, when? _______________________
Have you ever had bio-feedback therapy?_____ If yes, when? ____________________

For what condition? __________________________________________________________

Are you currently under the care of a physician? _____ If so, who, and for what
condition(s)?_________________________________________________________________

Main reason(s) for seeking consultation._____________________________________________________________________________________

How long have you experienced symptoms? _________________________________

Your condition is improved by
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Your condition is aggravated by
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
List all current medications, prescribed or over the counter

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List all current vitamins, herbs and other supplements

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Significant illnesses, current or past. (please check all that apply)

___ Cancer
___ Diabetes
___ Hepatitis
___ Heart Disease
___ Stroke
___ Seizures
___ HIV / AIDS
___ Pneumonia
___ Tuberculosis
___ Multiple sclerosis
___ Thyroid
___ Asthma
___ Stomach Ulcers
___ Obesity
___ Depression
___ Shingles
___ Chronic Fatigue
___ Rheumatic Fever
___ High Blood Pressure
___ STD's
___ Other __________
Please list any surgeries, injuries, scars, physical traumas, etc. you’ve had including dates:
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

Please list any Allergies:
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

Major emotional traumas you’ve experienced:
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

Lifestyle (please check all that apply, and note frequency of use):
___ Tobacco
___ Alcohol
___ Recreational Drugs
___ Caffeinated Beverages
___ Sugar / Processed & Pre-Packaged Foods / Fast Food

Do you exercise? _______ Please list types of activity and frequency:
**Dietary preferences**
- Vegetarian
- Raw foods diet
- Low fat diet
- High protein/low carb
- High protein / high fat
- Dairy / milk / cheese
- Eggs
- Chicken
- Fish / seafood
- Red meat
- Artificial sweeteners
- Fast food/ burgers/fries
- Spicy / hot
- Sweet
- Sour
- Salty
- Cold drinks
- Hot drinks
- Ice chewing
- Extreme thirst
- Thirst with no desire to drink

**General symptoms**
- Fatigue
- Sweat without exertion
- Night sweats
- Fever / chills
- Dizziness / vertigo
- Bleed / bruise easily
- Low immunity
- Other ____________

**Digestion**
- Extreme appetite
- No appetite
- Cravings
- Dieting
- Tired after eating
- Bloating
- Gas
- Acid regurgitation
___ Heartburn/Ulcers
___ GERD
___ Nausea
___ Vomiting
___ Bulimia
___ Anorexia
___ Irritability or low energy between meals
___ Other ________

How many meals per day? _______ How many snacks per day? ____________

**Intestinal**
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Anal fissures
___ Rectal prolapse
___ Intestinal pain/cramping
___ Incomplete evacuation
___ IBS
___ Colitis
___ Crohn’s Disease
___ Gout
___ Celiac Disease
___ Gallstones
___ Other ________

**Sleep**
___ Fall asleep easily
___ Lie in bed with eyes open
___ Wake as specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or Frightening dreams
___ Need drugs or supplements to fall asleep

**Head, Eyes, Ears, Nose and Throat**
___ Dry eyes
__ Spots / flowery vision
__ Blurred vision
__ Poor vision
__ Eye strain
__ Night blindness
__ Cataracts
__ Macular degeneration
__ Bleeding gums
__ TMJ
__ Sores on tongue or mouth
__ Dry mouth
__ Excess saliva
__ Sinus problems
__ Post-nasal drip
__ Sore throat
__ Headaches
__ Swollen glands
__ Difficulty swallowing
__ Earaches
__ Tinnitus / ringing
__ Deafness
__ Nosebleed
__ Other
___________________________

Cardiovascular / respiratory
__ Heart palpitations
__ Chest pain
__ Difficulty breathing
__ High cholesterol
__ Varicose veins
__ Blood clots
__ Swollen ankles
__ Heart valve abnormality
__ Shortness of breath
__ Cold hands / feet
__ Dry cough
__ Wheezing
__ Chest tightness
__ Difficult inhalation
__ Difficult exhalation
__ Productive cough (color of phlegm?)
___ Other ___________

**Skin / hair**
___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis
___ Pimples / acne
___ Fungal infections
___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other ___________

**Musculoskeletal**
___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis
___ Limited range of motion
___ Disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Other ___________

**Neuropsychological**
___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed
___ Poor memory
___ Seasonal mood disorder
___ Tics
___ Tremors
___ Death of someone close
___ Job stress
___ Recent divorce
___ Currently in therapy
Financial setback

Other

Emotional stress scale

1 2 3 4 5 6 7 8 9 10
no stress / moderate / extremely stressed

Rate your stress level regarding
Work _____
Health _____
Love _____
Money _____
Family ______
The future ______

Genito-urinary

___ Frequent urination
___ Loss of urine when laughing or sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Bladder Prolapse
___ Decreased libido / sexual desire
___ Other ____________

Men only

___ Enlarged prostate
___ Prostate cancer
___ Testicular cancer
___ Testicular pain or swelling
___ Erectile dysfunction
___ Impotency
___ STD’s ____________
Women only

Age menses began _______ Age menses ended (if applicable) ______________
Date of last Ob/Gyn exam _______________
Hysterectomy? ___ partial ___ full

___ Hormone replacement therapy
___ Live births
___ Miscarriage
___ Abortions
___ Infertility
___ Birth control pills
___ Breast cancer
___ Ovarian cysts
___ Fibroids
___ Endometriosis
___ Candida / yeast
___ Vaginal discharge
___ Vaginal odor
___ Vaginal sores
___ Herpes
___ Human Papilloma Virus positive
___ Uterine prolapse
___ STD history (Chlamydia, PID, etc)
___ Fibrocystic breast

Period lasts ______ days Usual number of days in cycle __________
Headaches ___ before menstrual cycle ___ during cycle ___ after cycle____
___ Pain at ovulation
___ Cramps / low back pain
___ Acne associated with period
___ Constipation associated with period
___ Diarrhea associated with period
___ Depression or irritability with period
___ Bleeding outside of normal menstrual cycle
___ No period / skipped cycles
___ Irregular cycle Menstrual flow
___ Clotting
___ Brownish
___ Watery, thin and bright red
___ Normal red
___ Flooding and trickling
___ Stop and start flow

If you have been evaluated for infertility, what was your diagnosis?
Payment and Cancellation Policies

Fees:

**Initial Acupuncture Visit:** $150 includes initial exam, acupuncture session, Bio-Mat session, brief nutritional QRA or LSA assessment, and dietary recommendations

**Follow-up Acupuncture Visit:** $80 includes only acupuncture & Bio-Mat. (Packages of 6 or 12 treatments are available at a discounted cash price. Must be paid in full at the time of purchase. Refunds on unused package sessions are prorated based on the individual session price of sessions used.)

**Basic QRA Nutrition Testing Session:** $150. 1 hour. Does not include the price of supplements. **Additional time is billed at $75 per 30 minutes.**

**Full Body QRA Nutrition Testing Session:** $300. 2 hours. Does not include the price of supplements. **Additional time is billed at $75 per 30 minutes.**

**Follow up Analysis QRA Session:** $75. per 30 minutes.

**Interference Field (IF) Testing:** $75. per 30 minutes. Identifies blockages that are creating stagnation in the flow of energy through the body’s meridians. These blockages may be caused by trauma to the body.

**Emotional Repolarization Technique (ERT):** $150 per hour. (approx. 1 hour)

**Cation Mud Therapy:** $50 per 20 minutes. Therapy for physical trauma sites / surgery scars.

**Nutrition / Dietary Counseling:** $150. 1 hour. Dietary recommendations, diet plan based on specific goals.

**Phone Consultation / Nutrition:** $60. per 30 minutes.

**Biofeedback (LSA) scan for nutrients and food sensitivities:** $50

**EVOX Therapy / Individual Session:** $150

**Transgenerational Initial Visit:** $200

**Transgenerational Package Pre-Paid (6 visits):** $800

Payment is by Credit Card (Visa or Mastercard), Flexible Spending or Health Savings Account, Check or Cash. Make checks payable to Central Florida Preventive Medicine. Full payment is expected at the time the services are rendered. A $60 charge for a check returned by the bank.

**Because supplements can be environment sensitive (heat, light, dampness), they cannot be returned or refunded after they are taken home by the patient. There are no refunds on nutritional supplements.**

If you must cancel your appointment, please give 48 hours notice if it all possible. Exceptions will be made for medical emergencies. **The full appointment ‘fee for service’ will be charged for all ‘no-shows’ or failure to cancel within 48 hours of appointment time.** You will be required to pre-pay for services after two ‘no-shows’ or failure to cancel within 48 hours of appointment time.

I, ________________________________, certify that I have read and understood the statements above and agree to abide by them.

Signature: _____________________________ Date: __________________
Consent for Treatment
Nutrition, Biofeedback, Acupuncture and other Holistic and Natural Therapies

I hereby request and consent to the performance of acupuncture and/or nutrition therapy sessions and other procedures within the scope of the practice of oriental medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, heat therapy, cupping, electrical stimulation, Tui-Na (Chinese Medical Massage), Cation mudpacks, poultices, herbal medicine, bio-feedback, muscle testing, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs and nutrients may be unpleasant to the taste or smell. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs or nutrients.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that this document describes the major risks of treatment, and that other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditional considered safe in the practice of Chinese and Holistic Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. Some detox effects may occur that are normal part of the body’s healing process. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature X ___________________________ Date __________________
Printed Name X ___________________________

Dr. Kathy Veon, DOM, AP
Central Florida Preventive Medicine, LLC