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.

Please turn all cell phones to 'Airplane Mode' and turn off all WiFi and Bluetooth capabilities while in the treatment room. Phones and other wireless devices must not be transmitting signals at any time, for any reason, while in the treatment room.

Scheduled Appointments: Please be courteous and arrive on time for all scheduled appointments as that time is set aside just for you. If you arrive more than 10 minutes late, your appointment will either be shortened or rescheduled, and you will be responsible for paying for the full fee for the 'late' appointment.

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 nutritional testing / functional medicine / muscle testing and for any follow up sessions, please trim orfile 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.

I have read and understood the instructions and office policies regarding cell phone and wireless device use:

Name_____Date: _____
Signed

Central Florida Preventive Medicine

Patient Intake Form -- 2023

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*)

___ COVID-19: _____ COVID Vaccination: Date(s) _____ Type_____
___ Flu Vaccines: _____
___ Other Vaccines: _____
____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
___ Neurological Issues
____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 / Vaping: _____
___Alcohol: _____
___Recreational Drugs
___Caffeinated Beverages
___Sugar / Processed & Pre-Packaged Foods / Fast Food
___ Wireless Radiation Exposure: WiFi, Cell Phone, Towers, Smart Devices, Bluetooth.
List and Explain in Detail: _____
_____

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
What is your Blood Type?: A / O / B / AB

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 stressscale

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:

***New Patient - Initial Acupuncture Visit*:** $250. includes initial exam, acupuncture session, Infrared mat session, brief nutritional assessment, and dietary recommendations.

Follow-up Acupuncture Visit: $90. includes only acupuncture & infrared. *(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)*

New Patient - Functional Medicine / Clinical Nutrition Session / QRA: $625. In-person, face-to-face, testing and hands-on diagnostics include: Full Body QRA, NAET 'Basic 15', Basic ERT concepts, and Interference Fields (IF's) from past injury sites: Total time: 2 hours
Abbreviated / Pediatric: $325. 1 hour.

Existing Patient - Follow-Up Consultations *(in-person, phone, email):* $150 for each 30 minutes

Pelotherapy/ Therapeutic Mud Therapy: $90 per 20 minutes. Therapy for physical trauma sites and surgery scars.

NAET Initial visit and treatment $285. 75 minutes.
NAET follow up visit and treatment $90. 30 minutes.

EVOX Therapy / Individual Session: $225.
Transgenerational Initial Visit: $295.
Transgenerational Package *Pre-Paid* (6 visits):
$1195. (savings of $225)

Payment is by Credit Card (Visa, MasterCard, AMEX or Discover), 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 *$40* charge for a check returned by the bank.

****Because supplements can be environment sensitive (heat, light, dampness, EMF's, etc.), 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

Clinical Nutrition, Biofeedback, Acupuncture, 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, NAET 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 a 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, DAOM, AP, CCN
Central Florida Preventive Medicine, LLC