

Patient Intake Form & Instructions / 2021

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 and you will be charged for the missed appointment.**

The office is located at:
1540 International Pkwy., #2000
Heathrow, FL 32746

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 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 QRA session (nutritional testing), Functional Medicine, Clinical Nutrition 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.

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 2021

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 at 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
- Dental/ Fillings/Root Canal
- 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: \$185 includes initial exam, acupuncture session, Infrared session, brief nutritional QRA or LSA assessment, and dietary recommendations

Follow-up Acupuncture Visit: \$80 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)

Basic Functional Medicine / QRA / Nutrition Testing Session Initial Visit: \$285. **1 hour.** Does not include the price of supplements. *Additional time is billed at \$150 per 30 minutes.*

Full Body Functional Medicine / QRA Nutrition Testing Session Initial Visit: \$570. **2 hours.** Does not include the price of supplements. *Additional time is billed at \$150 per 30 minutes.*

Follow up Functional Medicine / QRA / Nutrition: \$125. per 30 minutes.

Interference Field (IF) Testing: \$125. 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.

Pelotherapy / Therapeutic Mud Therapy: \$70 per 20 minutes. Therapy for physical trauma sites, surgery scars and injuries

NAET Initial visit and treatment \$185. 1 hour.

NAET follow up visit and treatment \$80. 30 minutes.

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

EVOX Therapy / Individual Session: \$195

Transgenerational Initial Visit: \$250

Transgenerational Package Pre-Paid (6 visits): \$1030.

Payment is by Credit Card (~~Visa, MasterCard, AMEX or Discover~~), **Flexible Spending** or **Health Savings Card, 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 all checks returned by the bank.

***** Because supplements are sensitive to environmental factors (heat, cold, EMF's) they cannot be returned or refunded after the patient takes them from the office. There are no returns or refunds on supplements.***

If you must cancel your appointment, please give **48 hour's notice** if 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 your appointment time.*** You will be required to pre-pay for services after 2 no-shows or failure to cancel within 48 hours' of your 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, 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