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 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 -- 2022

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________
___ 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

________________________________________________________________________

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________________________________________________________________________

Do you exercise? Yes/No

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:

**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**: $625. 90 minutes face-to-face + 30 minute email follow up with recommendations. Total time: 2 hours

**Pediatric New Patient – Functional Medicine / Clinical Nutrition Session**: $400. 60 minutes face-to-face + 30 minute email follow up with recommendations. Total time: 1 ½ hours. Does not include the price of supplements. Additional time is billed at $150 per 30 minutes.

**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 with 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