

## 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, smart devices, watches, etc. 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. This is for your health and safety and to protect the health and safety of the doctor treating you.***

***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 NAET or 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, including those regarding cell phone and wireless device use:

Name \_\_\_\_\_ Date: \_\_\_\_\_  
Signed

Central Florida Preventive Medicine  
New 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

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List all current vitamins, herbs and other supplements

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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

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Please list any Allergies

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Major emotional traumas you've experienced

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**Lifestyle** *(please check all that apply, and note frequency of use)*

\_\_\_ Tobacco / Vaping: \_\_\_\_\_

\_\_\_ Alcohol: \_\_\_\_\_

\_\_\_ Recreational Drugs / Cannabis: \_\_\_\_\_

\_\_\_ Caffeinated Beverages: \_\_\_\_\_

\_\_\_ Sugar / Processed & Pre-Packaged Foods / Fast Food: \_\_\_\_\_

\_\_\_ Wireless Radiation Exposure: WiFi, Cell Phone, Towers, Smart Devices, Bluetooth.

*List and Explain in Detail:* \_\_\_\_\_

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Do you exercise? \_\_\_\_\_ Please list types of activity and frequency:

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### **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 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
  - Other
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### **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 Policy

### Fees:

**New Patient - Functional Medicine / Clinical Nutrition Session / QRA:** \$725. In-person, face-to-face consultation, testing and hands-on diagnostics include: Full Body QRA, NAET 'Basic 15', Clinical Nutrition, Functional Medicine, Basic ERT concepts, and identifying Interference Fields (IF's) from past injury sites, review of lab findings (if ordered), nutrition, diet and lifestyle recommendations, and full healing protocol with interpretation:

Total in-office time: up to 2 hours

**Abbreviated or Pediatric:** \$375. Up to 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** \$325. 90 minutes.

**NAET follow up visit and treatment** \$125. 30 minutes.

**NAET package of 12 treatments** \$1200. (savings of \$300)

**Single 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)

**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, Functional Medicine, Biofeedback, NAET, Acupuncture, QRA,  
Cranial Release Technique (CRT), Pelotherapy, EVOX Perception Reframing  
Therapy, and all 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 (Pelotherapy), poultices, herbal medicine, bio-feedback, muscle testing, NAET, clinical nutrition, nutritional counseling and diet and lifestyle 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