

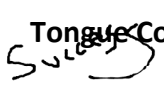
AP Name:  
LICENSE NUMBER(S):

8330 SW 8<sup>TH</sup> STREET,  
MIAMI, FL 33144



Patient Name:		BP:	Date: <b>3/20/2017</b>
<b>Subjective(S)/Objective(O):</b> Notes regarding the Patients general condition and changes since last seen, including response to any prior treatment or herbal formula:			
Appointment Start Time: _____		Appointment End Time : _____	
Presenting Problems:			
Symptom:			
1. Chills/Fever: <input checked="" type="checkbox"/> None <input type="checkbox"/> S <input type="checkbox"/> O		2. Perspiration: <input type="checkbox"/> None <input type="checkbox"/> S <input type="checkbox"/> O	
3. Thirst: <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O		4. Urination: <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O	
5. Headache/Body Pain: <input type="checkbox"/> None		6. Respiration: <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O	
7. Sleep/Energy: <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O		8. Reproductive: <input type="checkbox"/> Normal	
9. Mental/Emotional: <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O		10. Ears/Eyes/Teeth/Gums: <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O	
11. Appetite/Digestion/Defecation: <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O		12. Palpitation/Dizziness/Numbness: <input type="checkbox"/> None <input type="checkbox"/> S <input type="checkbox"/> O	

**Tongue Diagnosis:**

- Body Color:
- Body Shape:
- Tongue Coating:  

- Coat Coloration:
- Coat Rooting:

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**(O) Other Physical Exams:**

Facial colors, eyes, abdominal diagnoses, odor, sound of voice,

Orthopedic exams, body language, skin, nails, hair

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Pulse Quality:**

**Right:** \_\_\_\_\_

**Left:** \_\_\_\_\_

**Assessment & Diagnosis:** \_\_\_\_\_

\_\_\_\_\_

**Treatment Principles:** \_\_\_\_\_

\_\_\_\_\_

**Plan of Treatment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Needling Sets:**

☐ Clean needle technique practiced

**1<sup>st</sup> Set of Needles:**

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**2<sup>nd</sup> Set of Needles:**

☐ Electrical Stimulation

☒ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**3<sup>rd</sup> Set of Needles:**

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**4<sup>th</sup> Set of Needles:**

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**5<sup>th</sup> Set of Needles:**

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**6<sup>th</sup> Set of Needles:**

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

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<input type="checkbox"/> Taking Herbs	<input type="checkbox"/> Not Taking Herbs	<input type="checkbox"/> Prepared Medicine	<input type="checkbox"/> See Herb Ingredient Sheet
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Herbal Formula (Please indicate lot #): \_\_\_\_\_

Direction of Intake: \_\_\_\_\_

Herbal Formula (Please indicate lot #): \_\_\_\_\_

Direction of Intake: \_\_\_\_\_

Herbal Formula (Please indicate lot #): \_\_\_\_\_

Direction of Intake: \_\_\_\_\_

Post Treatment Assessment: \_\_\_\_\_

\_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_