

AP Name: Betty

8330 SW 8<sup>TH</sup> STREET,

LICENSE NUMBER(S): TestData TestData Test Data Test MIAMI, FL 33144



<b>Patient Name:</b> TestData TestData Test Data TestData TestData Test Data		<b>BP:</b> 60/60	<b>Date:</b> 5/3/2017
<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: TestData TestData Test Data TestData TestData Test Data			
<b>Appointment Start Time:</b> <u>TestData TestData Test Data</u>		<b>Appointment End Time :</b> <u>TestData TestData Test Data</u>	
<b>Presenting Problems:</b> TestData TestData Test Data TestData TestData Test Data			
<b>Symptom:</b> TestData TestData Test Data TestData TestData Test Data			
<b>1. Chills/Fever:</b> <input type="checkbox"/> None <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data		<b>2. Perspiration:</b> <input type="checkbox"/> None <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data	
<b>3. Thirst:</b> <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data		<b>4. Urination:</b> <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data	
<b>5. Headache/Body Pain:</b> <input type="checkbox"/> None TestData TestData Test Data TestData TestData Test Data		<b>6. Respiration:</b> <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data	
<b>7. Sleep/Energy:</b> <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data		<b>8. Reproductive:</b> <input type="checkbox"/> Normal TestData TestData Test Data TestData TestData Test Data	
<b>9. Mental/Emotional:</b> <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data		<b>10. Ears/Eyes/Teeth/Gums:</b> <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data	
<b>11. Appetite/Digestion/Defecation:</b> <input type="checkbox"/> Normal <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data		<b>12. Palpitation/Dizziness/Numbness:</b> <input type="checkbox"/> None <input type="checkbox"/> S <input type="checkbox"/> O TestData TestData Test Data TestData TestData Test Data	

**Tongue Diagnosis:**

- **Body Color:** Pale
- **Body Shape:** Deviated
- **Tongue Coating:** Thick
- **Coat Coloration:** White
- **Coat Rooting:** Rooted

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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:** TestData TestData Test Data TestData TestData Test Data

**Pulse Quality:**

**Right:** Wiry, Taut

**Left:**

**Assessment & Diagnosis:** Heart Blood Deficiency

**Treatment Principles:** Harmonize LV & SP, Subdue LV Yang

**Plan of Treatment:** Cupping Therapy / Gua-Sha Therapy

**Needling Sets:**

☐ Clean needle technique practiced

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

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

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

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**3<sup>rd</sup> Set of Needles:** LU-2

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**4<sup>th</sup> Set of Needles:** LU-1

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**5<sup>th</sup> Set of Needles:** LU-2

☐ Electrical Stimulation

☐ Tui – Na \_\_\_\_\_

☐ Cupping Therapy

**6<sup>th</sup> Set of Needles:** LU-2

☐ 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 #): Gui Zi Fu Ling Pian

Direction of Intake: TestData TestData Test Data TestData TestData Test Data

Herbal Formula (Please indicate lot #): Kang Zhong Pian

Direction of Intake: TestData TestData Test Data TestData TestData Test Data

Herbal Formula (Please indicate lot #): Qing Fei Tang

Direction of Intake: TestData TestData Test Data TestData TestData Test Data

Post Treatment Assessment:

TestData TestData Test Data TestData TestData Test Data

Recommendations:

TestData TestData Test Data TestData TestData Test Data

Signature

5/3/2017

Date