AP Name:
LICENSE NUMBER(S):

8330 SW 8TH STREET,
MIAMI, FL 33144

BA Natural BODY CARE

Patient Name:	BP:	Date: 3/20/2017

Subjective(S)/Objective(O): 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: ■ None □ S □ O	2. Perspiration: □ None □ S □ O
3. Thirst: □ Normal □ S □ O	4. Urination: □ Normal □ S □ O
5. Headache/Body Pain: □ None	6. Respiration: □ Normal □ S □ O
7. Sleep/Energy: □ Normal □ S □ O	8. Reproductive: □ Normal
9. Mental/Emotional: □ Normal □ S □ O	10. Ears/Eyes/Teeth/Gums: □ Normal □ S □ O
11. Appetite/Digestion/Defecation: □ Normal □ S □ O	12. Palpitation/Dizziness/Numbness: □ None □ S □ O

Tongue Diagnosis:

- **Body Color:**
- **Body Shape:**
- **Tongue Coating:** Sweet
- **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**

1st Set of Needles:

□ **Electrical Stimulation** □ **Tui – Na _____** □ **Cupping Therapy**

2nd Set of Needles:

□ **Electrical Stimulation** ■ **Tui – Na _____** □ **Cupping Therapy**

3rd Set of Needles:

□ **Electrical Stimulation** □ **Tui – Na _____** □ **Cupping Therapy**

4th Set of Needles:

□ **Electrical Stimulation** □ **Tui – Na _____** □ **Cupping Therapy**

5th Set of Needles:

□ **Electrical Stimulation** □ **Tui – Na _____** □ **Cupping Therapy**

6th Set of Needles:

□ **Electrical Stimulation** □ **Tui – Na _____** □ **Cupping Therapy**

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☐ Taking Herbs	☐ Not Taking Herbs	☐ Prepared Medicine	☐ See Herb Ingredient Sheet

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**