

AP Name:
LICENSE NUMBER(S):

8330 SW 8TH STREET,
MIAMI, FL 33144



Patient Name:		BP:	Date:
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: <input 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

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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<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