

Patient Name: TYLER THE TESTER		BP:	Date: 8/19/2017
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: <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:

AP Name: Chao Lung Liu  
LICENSE NUMBER(S): AP2883

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

**(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

8/19/2017  
\_\_\_\_\_  
Date