Florida College of Integrative Medicine

PATIENT INTAKE FORM/ INFORMACION DEL PACIENTE

Name/Nombre_____ Date/Fecha _____

Date of Birth / Fecha de nacimiento_____ Gender: ☐Male/Masculino ☐Female/ Femenino

NOW: ☐ **PREGNANT/EMBARAZADA** ☐ **PACEMAKER/MARCA PASO** ☐ **HIV DISEASE/VIH** ☐ **HEPATITIS** ☐ **BLOOD TRANSFUSION/TRANSFUSION SANGUINEA**

FAMILY HISTORY / HISTORIAL FAMILIAR:

☐ Abuse/Abuso ☐ AIDS/SIDA ☐ Alcoholism/Alcolismo ☐ Allergies/Alergias ☐ Asthma ☐ Cancer ☐ Chemical Dependency/Farmaco dependencia ☐ Diabetes ☐ Heart Disease/Enfermedades de Corazon ☐ High Blood Pressure/Alta Presion ☐ Mental Illness/Enfermedad Mental ☐ Respiratory Diseases/Enfermedades Respiratorias ☐ Seizures/ Convulsiones ☐ Stroke/Infarto ☐ Other/ Otros_____

YOUR PAST MEDICAL HISTORY/ILLNESSES: ☐ Other:_____

Historial de enfermedades Pasadas/Presente: Otras

☐ Aids/HIV/VIH ☐ Alcoholism/Alcolismo ☐ Allergies/Alergias ☐ Anemia ☐ Arthritis/Artritis ☐ Asthma/Asma ☐ Auto Immune Disease/Enfermedad Autoinmune ☐ Bleeding Disease / Hemorrajias ☐ Breast Cysts / Quiste Seno ☐ Bi Polar ☐ Bronchitis ☐ Cancer ☐ Candida (Yeast) ☐ Chemical Dependency / Farmaco Dependencia ☐ Chronic Fatigue Syndrome / Syndrome de Fatiga Cronica ☐ Chronic Lung Disease / Enf Cronica de Pulmon ☐ Colitis ☐ Diabetes ☐ Eating Disorder / Desorden Alimenticio ☐ Fracture / Fracturas ☐ Glaucoma ☐ Gall Stones / Calculos ☐ Gout / Gota ☐ Headaches / Dolor de Cabeza ☐ Heart Disease / Enfermedad de Corazon ☐ Hepatitis ☐ Hernia ☐ Herniated disc / Herniado ☐ High Blood Pressure / Presion Alta ☐ High Cholesterol / Colesterol Alto ☐ Kidney Disease / Enfermedad de Riñon ☐ Liver Disease / Enfermedad de Higado ☐ Low blood pressure / Baja Presion ☐ Migraine / Migrana ☐ Mononucleosis ☐ Multiple Sclerosis / Esclerosis Multiple ☐ Mental Illness / Enfermedad Mental ☐ Osteoporosis ☐ Organ Transplant / Transplante de Organo ☐ Parkinson's ☐ Pneumonia ☐ Prostate problems / Problema de Prostata ☐ Rheumatic Fever / Fiebre Reumatica ☐ Seizures/Epilepsy / Convulciones/Epilepsia ☐ Sexually Transmitted Diseases (STD) / Enfermedades transmitidas sexualmente ☐ Stroke / Infarto ☐ Substance Abuse/Addiction / Adicciones ☐ Suicide attempt / Intento de Suicido ☐ Thyroid Disease / Enfermedad de Tiroide ☐ Tuberculosis ☐ Ulcers / Ulceras ☐ Vaccine Reaction / Reaccion a vacunas ☐ Whooping Cough / Tos Perruna

SURGERIES: (Please include dates and if any complications)
Cirujias: (indique Fecha y complicasiones)

1 -_____ 2_____
3- _____ 4_____

TRAUMATIC INJURY: (Please include dates and if any complications)
Lesiones traumatica: (Indique fecha y Complicaciones)

Car accident / Accidente Automotriz
Falls / Caidas
Other

ALLERGIES / ALERGIAS

Drugs/Medication
Medicamentos
Chemicals?/ farmacos
Food / Comida _____ Seasonal/Environmental / Ambientales/Estaciones _____

CURRENT MEDICATIONS:
Medicamentos Actuales:

Chemical: Acid/Alkalines:
Quimicas: Acido/Alcalinos

OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:

Exposiciones peligrosas ambientales/Trabajo:

Heavy Metals: Physical Labor:
Metales Pesados Labor Fisica
Electrical: Psychological:
Electricas psycologicas

HABITS/EXCESSIVE USAGE: (Please tell us how often & how much)

Habitos/Uso excesivo: (Indique frequencia y cantidad)

☐ alcohol_____ ☐ artificial sweetener/endulsadores artificiales_____ ☐ chocolate_____
☐ cigarettes/ cigarrillos _____ ☐ coffee/ café _____ ☐ cola_____ ☐ drugs/drogas_____
☐ exercise/ejercicios_____ ☐ food/comida_____ ☐ salt/sal_____ ☐ sex/sexo_____
☐ sugar/azucar_____ ☐ tea/te_____ ☐ water/ agua _____ ☐ other/otro_____

CHIEF COMPLAINT / REASON FOR YOUR VISIT:

Queja Principal/ Razon de su Visita _____
How and when did this condition begin?_____
Cuando y como comenzo esta condicion?_____
Please list your main health concerns you would like to be free of, in order of importance:
Haga una lista de los problemas de salud que usted desea aliviar:
1. _____ 2._____
3._____ 4. _____

GENERAL (Please check all that apply to you within the last 3 months)
GENERAL (favor indicar todo lo que le apliqué en los ultimos 3 meses)

☐ poor appetite
poco apetito
☐ change in appetite
cambio de apetito
☐ large appetite
apetito abundante
☐ cravings
antojos
☐ weight gain
aumento de peso
☐ weight loss
perdida de peso
☐ diff loosing/gaining w
dif perdida/aumento peso
☐ fevers
fiebres
☐ chills
escalofrio
☐ sweating
sudor
☐ night sweats
sudor nocturno
☐ sweats easily
suda facilmente
☐ hot flashes
calores
☐ mental fog
☐ edema

☐ insomnia
insomnia
☐ hours of sleep
horas de sueno
☐ easy to fall asleep
duerme con facilidad
☐ heavy sleeper
duerme con profundidad
☐ light sleeper
sueno liviano
☐ disturbing dreams
pesadilla
eight ☐ sleep walking
sonambulo
☐ excessive need for sleep
somnolencia
☐ trouble staying asleep
dif en permanecer dormido
☐ trouble falling asleep
dif para dormirce
☐ sleep apnea
se despierta sin aire
☐ dizziness
mareado
☐ headache
dolor de cabezas
☐ tremors/shaking
temblores
☐ poor coordination
☐ vertigo

☐ bleeds easily
sangra con facilidad
☐ bruises easily
se lesiona facil
☐ chronic fatigue
fatiga cronica
☐ lethargy
letargia
☐ fatigue/tired
fatiga/cansancio
☐ sudden drop in energy
bajon de energia
☐ weakness
debilidad
☐ work odd hours
horas raras de trabajo
☐bitter taste
gusto amargo
Are you taking:
Esta tomando
☐ Aspirin
Aspirina
☐ Blood Thinners
cuagulantes
☐ Vitamins
vitaminas
☐ Herbs
☐ Supplements

Energy level: ☐ high ☐ moderate ☐ low
Nivel de energia alto moderado bajo
Thirsty, desires: ☐ hot ☐ cold
Sed, desea caliente frio
☐ room temp. ☐ no desire
temp. ambiente no desea
Coldness: ☐ hands ☐ feet ☐ back
Frio: manos pies espalda
Heat: ☐ hands ☐ feet ☐ solar plexus /
Calor: manos pies plexo solar
☐ abdomen ☐ whole body
abdomen cuerpo completo
Stiffness: ☐ joints ☐ back ☐ limbs
Riguides articulaciones espalda brasos/ piernas
Intolerance to: ☐ hot ☐ cold ☐ wind
Intolerancia: calor frio viento
☐ fan ☐ A/C
abanico A/C
Do you follow a special diet: ☐ yes ☐ no
Sigue alguna dieta especial si no
If so, please explain: _____
favor explique
_____
_____
Do you make time for relaxation/meditation/ prayer? ☐ yes ☐ no
Dedica tiempo paraa relajarce/meditar
nuves mentales coordinacion pobre
Hierbas Reza si no

edema vertigo suplementos

SKIN AND HAIR (Please check all that apply to you within the last 3 months)
PIEL Y PELO (indique todo lo que le apliqué en los ultimos 3 meses)

☐ rashes erupciones ☐ psoriasis soriasis ☐ itching picor ☐ thinning of hair Perdida de cabello
☐ eczema eczema ☐ eruptions erupsiones ☐ fungal/yeast infection Hongo/ inf de levadura ☐ change in hair cambio en el cabello
skin: ☐ dry ☐ moist ☐ discharge ☐ change in skin texture ☐ other hair problems:
Piel: seca humeda supuraciones cambio en la textura otros problemas de cabello
☐ sores aftas ☐ pimples/acne acne ☐ dandruff caspa
☐ ulcers ulceras ☐ bruises trauma ☐ loss of hair perdida de cabello ☐ other skin problems: otros problemas de piel
☐ herpes herpes ☐ hives errupcion/alergias ☐ balding calvicie

HEAD, EYES, EARS, NOSE, MOUTH & THROAT(Please check all that apply to you within the last 3 months) CABEZA, HOJOS, OIDOS, NARIZ, BOCA y CUELLO (indique todo lo que le appliqué en los ultimos 3 meses)

Head **Cabeza**	**Eyes (R/L)** **Hojos(D/I)**	**Ears (R/L)** **Oidos (D/I)**	**Nose** **Nariz**	**Mouth** **Boca**	**Throat** **Cuello**
☐ dizziness mareos	☐ cataract/ catarata	☐ loss of hearing perdida de audicion	☐ loss of smell perdida de olfato	☐ grind teeth rechina dientes	☐ dry throat garganta seca
☐ migraine migranas	glaucoma glaucoma	☐ discharge secreciones	☐ good sense of smell buen sentido olfato	☐ drooling babeo	☐ hoarseness cambio de voz
Headaches: **Dolor de cabza**:	☐ eye pain dolor de ojo	☐ earaches dolor de oido	☐ nose bleeds sangramientos nasals	☐ excess saliva saliva excesiva	☐ recurrent recurrente
☐ frontal **frontal**	☐ twitching **mov imvoluntario**	☐ poor hearing audicion pobre	☐ allergies alergias	☐ dry mouth sequedad bucal	sore throat dolor de garganta
☐ temporal temporal	☐ floaters/spots flotantes	☐ itchiness picor	☐ nasal discharge secrecion nasal	☐ gum disease enf de encias	☐ loss of voice perdida de voz
☐ vertex vortex	☐ poor vision pobre vision	***Ringing in ears***: **Ruidos en el oido:**	***color***: ☐ yellow **color:** Amarillo	☐ bad breath mal aliento	☐ difficulty dificultad
☐ occipital occipital	☐ blurry vision vision borroza	☐ loud ☐ soft alto suave	☐ white ☐ clear blanco claro	☐ gum bleeding sangre encia	edema swallowing
☐ head injury trauma de cabeza	☐ night blindness seguera nocturna	☐ high pitch ruido alto	☐ green verde	☐ gum swelling edema en la encia	☐ "lump in troat" "bulto en garganta"
☐ facial pain dolor facial	☐ itchiness picor	☐ low pitch tono bajo	***amount***: **cantidad**:	☐ scanty escaso	☐ taste in mouth sabor en la boca
☐ facial paralysis paralysis facial	☐ glasses/contacts espejuelos/contactos	☐ inflammation inflamacion	☐ mod moderado	☐ heavy pesado	☐ ulcers ulcera ☐ frequent frequencia
☐ sinus problems problema de sinositis	☐ red eyes hojos rojo	☐ tenderness sensitividad	☐ thick grueso	☐ thin fino	☐ sores ulceras tonsillitis amigdalitis
☐heaviness in head pesades de cabeza	other:_____ otros	other:_____ otros	☐ dry nose nariz seca	☐ dry lips labios secos	☐ freq.Troat clearing garraspera
			other / otros _____		

CARDIOVASCULAR (Please check all that apply to you within the last 3 months)
CARDIOVASCULAR (indique tolo lo que le apliqué en los ultimos 3 meses)

☐ high blood pressure alta presion ☐ chest pain dolor de pecho ☐ difficulty in breathing dif en respirar ☐ coma coma
☐ low blood pressure presion baja ☐ cold hands/feet manos fria ☐ shortness of breath falta de aliento ☐ loss of consciousness perdida de consiencia
☐ dizziness mareos ☐ swelling hands/feet edem manos/pies ☐ dream disturbance pesadillas ☐ heart pounding palpitaciones cardiacas
☐ fainting desmayo ☐ irregular heart beat pulsaciones cardiacas irregulars ☐ poor memory memoria pobre ☐ stifling sensation in chest pecho trancado

☐ palpitations palpitaciones ☐ insomnia insomnia ☐ mania/delirium mania/alucinaciones other: otros:

RESPIRATORY (Please check all that apply to you within the last 3 months)
RESPIRATORIO (indique todo lo que le apliqué en losultimos 3 meses)

☐ pneumonia neumonia
☐ bronchitis bronquitis
☐ asthma asma
☐ coughing blood tose sangre
☐ wheezing silvido en pecho
☐ frequent colds catarros frequentes
☐ chronic cough tos cronica

cough: how long?
Tos: cuanto tiempo?
☐ dry seca ☐ croup perruda ☐ rapid seguida ☐ other otra
phlegm: ☐ thin fina ☐ thick espeza ☐ clear clara
flema
☐ white blanca ☐ yellow amarilla ☐ green verde
☐ tightness in chest oppression en pecho ☐ allergies alergias
☐ sinus infection sinusitis ☐ post nasal drip goteo postnasal
☐ sinus congestion congestion nasal ☐ heaviness in chest pesadez en pecho

☐ shortness of breath Falta de aliento
☐ fullness in chest pesadez en el pecho
difficulty breathing:
difficultad para respirar
☐ sitting sentado ☐ lying down acostado
☐ difficulty inhaling or exhaling dificultad inhalado/exhalando
☐ frequent sighing suspiraciones
☐ other chest discomfort otras molestias de pecho

GASTROINTESTINAL (Please check all that apply to you within the last 3 months)
GASTROINTESTINAL (indique todo lo que le apliqué en los ultimos 3 meses)

☐ food allergies alergias a comidas
☐ vomiting vomito
☐ cramping calambres
☐ gas after meals gases despues de las comidas
☐ abd/stomach pain dolor abdominal
☐ nausea nausea
☐ overeat llenura
☐ tastelessness perdida de sabor
☐ fatigue after eating fatiga luego de comer

☐ taste in mouth sabor en la boca
☐ belching gases
☐ bad breath mal aliento
☐ hiccup hipo
☐ constipation estrellimiento
☐ diarrhea diarreah
☐ mouth sores ulceras bucales
☐ heart burn/reflux swallowing reflujo
☐ bulimia bulimia

☐ loose stools heces sueltas
☐ bloody/black stools heces negras/oscuras
☐ ulcers ulceras
☐ increased appetite aumento en apetito
☐ poor appetite pobre apetito
☐ hungry-no desire to eat ambre sin apetito
☐ "nervous stomach" "estomago nervioso"
☐ cravings antojos

☐ difficult stools heces dificiles
☐ mucus in stools heces con mucosidad
☐ hemorrhoids hemorroides
☐ hernia hernias
☐ rectal pain dolor rectal
☐ rectal bleeding sangremiento rectal
☐ dry, hard stools heces secas/duras
☐ flucttion ls fluctuacion en heces fecales
☐ gall stones calculus billiares

☐ tenderness in abdomen sensotividad en abdomen
☐ fullness in abdomen llenura en abdomen
☐ burning in abdomen quemason en abdomen
☐ like/dislike pressure gusta/disgusta presion abd
☐ like/dislike cold gusta/no gusta frio
☐ like/dislike warmth gusta/no gusta calor
☐ pain with passing stool dolar al defecar
☐ difficulty dificultad al tragar

GENITO-URINARY (Please check all that apply to you within the last 3 months)
GENITO-URINARIO (indique todo lo que le apliqué en los ultimos 3 meses)

☐ burning /painful urine ardor/dolor al orinar
color: ☐ cloudy ☐ pale ☐ dribbling urine
Color: nuboso palido goteo
☐ dk yellow ☐ pink/red
Amarillo oscuro rosado/rojo
☐ unable to hold urine de aguantar la orina
☐ urgency to urinate miccion con urgencia

☐ poor stream/scanty urine orina escasa
☐ frequent urination frequencia de miccion
☐ sexually active ? sexualmente activo

☐ diminished sex drive disminucion deseo sexual
☐ increased sex drive aumento de libido
☐ unable to urinate incapacidad de orinar
☐ genital itching picor genital
☐ genital sores/pain chancros genitales

☐ discharge secreciones
☐ history of kidney stones historial calculos renales
☐ impotency impotencia
☐ history of bladder infections infecciones de vejiga
☐ history of prostate problems incapacidad historial problemas de prosteta
☐ history of STD historial de ETS

☐ wakes up to urinate more than once per night How many times?_____
despierta mas de una vez para orinar. Cuantas vezes?_____

NEUROPHYSIOLOGICAL (Please check all that apply to you within the last 3 months)

NEUROPHYSIOLOGICO (Indique todo lo que le apliqué en los ultimos 3 meses)

☐ history of mental illness historial de enf mentales	☐ melancholy melancolia	☐ joyful alegre	☐ tremors/shaking temblores
☐ depression depresion	☐ grieving luto/perdidi	☐ giddy se rie mucho	☐ convulsions convulsiones
☐ anxiety ansiedad	☐ easy to anger facil de enojar	☐ over-thinking piensa demasiado	☐ coma coma
☐ easily stressed facil de estrezarse	☐ irritability irritabilidad	☐ talkative hablador	☐ concussion contusion
☐ confusion/foggy confusion/neblura	☐ restlessness inquietud	☐ silent callado	☐ paralysis paralysis
☐ lack of clarity falta de claridad	☐ emotional emocional	☐ extrovert extrovertido	☐ trauma at birth nacimiento traumatico
☐ moody mal genio	☐ frequent sighing suspiros frequentes	☐ introvert introvertido	☐ vaginal delivery ☐ cesarean nacimiento vaginal cesaria
☐ fear/fright miedo/sustos	☐ over-worried preocupacion exseciva	☐ poor memory mala memoria	☐ considered/attempted suicide considero/intento suicidio
☐ hyper hyperactivo	☐ bad-tempered mal genio	☐ seizures ataques	☐ unable to focus inhabilida para concentrarse
☐ sadness tristeza	☐ tics movimiento involuntario	☐ panic panico	☐ phobia fobias
☐ frustration frustraciones	☐ hopelessness desesperanza	☐ feeling stuck siente que no progressa	☐ seeing therapist recibiendo terapista

MEN'S HEALTH (Please check all that apply to you within the last 3 months)

SALUD MASCULINA (Indique todo lo que le apliqué en los ultimos 3 meses)

☐ prostate problems problemas de prostata	☐ swellings, lumps and pain in testicles inchazon, bultos /dolor testicular	☐ discharge from penis secrecion del pene
☐ decreased libido disminucion de libido	☐ cold feeling in genitals sensacion genitalia fria	☐ difficult achieving and maintaining erection dificultad en obtener /mantener ereccion
☐ hernia herni hernia	☐ difficult ejaculation ejaculacion con dificultad eyaculacion con dificultad	☐ injury to reproductive organs organo reproductivo lastimados lastimado organos reproductibo
☐ infertility infertilidad	☐ painful erections recciones dolorosas	☐ currently sexually active sexualmente activo en la actualidad

☐ history of STD / historial de ETS ☐ other/otros:_____

MUSCULO-SKELETAL (Please check all that apply to you within the last 3 months)

MUSCULO-ESQUELETO (Indique trodo lo que le apliqué en los ultimos 3 meses)

Area:: ☐ face/cara ☐ jaw/quijada ☐ chest/pecho ☐ epigastric area/area epigastrica ☐ rib cage/costales
☐ low abdominal/abdomen bajo ☐ pelvic/pelvis ☐ genitals/genitales ☐ neck/cuello ☐ shoulder/hombros ☐ fingers/dedos
☐ upper back/espalda sup ☐ mid back/espalda med ☐ knee/rodilla ☐ lower back/espalda baja ☐ sacrum/tailbone/coxis
☐ sciatica/ciatica ☐ upper limbs/miembros superiores ☐ lower limbs /miembros inferiores ☐ feet/pies ☐ whole body/cuerpo completo
☐ bone/hueso ☐ muscle/musculo ☐ joint/cojuntura

Rate the pain: Scale 1-10 (10 worst)/ **Indique** intensidad del dolor escala 1-10 (10 es lo peor) 1 2 3 4 5 6 7 8 9 10

Please indicate which side is affected/ Indique que lado esta afectado***:***_____ _____

How often is the pain present?/ Que porciento de tiempo esta este dolor presente?☐0-25% ☐26-50% ☐51-75% ☐76-100%

Do you often carry heavy objects?/ Carga usted objetos pesados? ☐ not often/no frecuente ☐ often/frecuente

Is your pain/ Es su dolor? ***:*** ☐fixed/fijo ☐moves around/se mueve ☐radiates/iradia ☐sharp/cortante ☐dull/pesado

Is the pain ☐***aggravated by*** ☐***alleviated by:*** ☐ sitting ☐ standing ☐ movement ☐ pressure ☐ warmth
El dolor se agrava con se alivia con: sentado parado movimiento presion calor
☐ cold/frio ☐ other/
otro:_____

Do you have? ☐ pain ☐ swelling ☐ burning ☐ weakness ☐ numbness ☐ tingling ☐ arthritis ☐ clicking
Tiena usted dolor inchades quemazon debilidad area dormidad hormiguero arthritis
☐ stiffness ☐ spasms ☐ twitching ☐ shaking ☐ soreness ☐ tenderness ☐ unsteadiness ☐ tension
rijidez espasmos adolorido sensitibidad desequiloibrio tension
☐ heaviness ☐ better with movement ☐ worse with movement ☐ hernia
pesadez major con movimiento peor con m ovimiento hernia

GYNECOLOGY AND PREGNANCY (Please check all that apply to you within the last 3 months)
GYNECOLOGICO Y EMBARRAZO (Indique todo lo que le apliqué en los ultimos 3 meses)

Date of last PAP/ Fecha de ultimo PAP:_____ Last Menstrual Period/ Ultima menstruacion:_____
☐ endometriosis ***color*****:** ☐ pale red/rojo palido ☐ light red/rojo claro ☐ currently sexually active/ sexualmente active
☐ pregnant currently/ embarazada ☐ pelvic pain/ dolor`pelvico ☐ red/rojo ☐ dark red / rojo oscuro
☐ # of pregnancies/# de embarazos _____ ☐ # of live births/ num. Parto ☐ no. of miscarriages/# de Abortos naturales _____
☐ # of abortions/# de Abortos Inducidos_____ ☐ # of premature birth/ # nacimiento prematuro _____
☐ age at first menses/edad primera menstruacion ☐ fibroids/fibroma
☐ red/purple /rojo purpura ☐ purple/purpura ☐ length of period/ duracion periodo _____
☐ abd. Bloating/fullness/ distencion/llenura abd ☐ dk purple/ purpura oscura ☐ brown/carmelita
☐ spotting between periods ***clots/*** manchas entre ciclos cuagulos**:** ☐ large/grandes ☐ small/ pequenos
☐ early menstrual cycle(less 21 days)/ periodo temprana ☐ mood change before period/ cambio de humor antes de periodo
☐ body change before period /cambio corporal antes periodo ☐ late menstrual cycle (less than 35 days)/ periodo tarde (menos de 35 dias
Menstrual pain/cramps/Dolor de Periodo: ☐ before/antes ☐ during/durante ☐ after/despues
Vaginal discharge/ Descarga vaginal**:**
☐ odor/olor ☐ no odor/no olor watery/aguado thick/espezo curdy/cortado itchy/picor ***color***: ☐ clear/claro ☐ white/blanco
☐ yellow/amarillo ☐ bloody/sangriento
☐ infertility/infertilidad ☐ pain during intercourse/ dolor durante relaciones sexuales ☐ irregular menstrual cycle/ periodo irregular
☐ days of heavy flow/dias de flujo pesado_____☐ uterine prolaps/ prolapso uterino
☐ ***menopause/menopausa***: ☐ pre ☐ post ☐ endometriosis

birth control pills: ☐ age at menopause ***flow***: ☐ thick ☐ thin ☐ vaginal burning/itching
pildora control de natalidad edad de menopausea **flujo**: mucho fino pocor/calenture vaginal
type ☐ history of ovarian cysts ***amount***: ☐ scanty ☐ mod ☐ vaginal pain
tipo historiao quistes ovaries **cantidad escazos mod** dolor vaginal
how long? ☐ history of uterine problems ☐ heavy ☐ very heavy ☐ genital eruptions
cuanto tiempo? Historial problemas uterinos pesado muy pesado erupciones genitales
☐ hormone replacement ☐ decreased libido ☐ absent menstruation
remplaso hormonal disminucion de libido periodo ausente

BREAST (Please check all that apply to you within the last 3 months) SENOS (ultimos 3 meses)

☐ history of breast disease ☐ breast tenderness ***breast discharge***: ☐ clear ☐ white ☐ yellow ☐ green
historial de enfermedades del seno sensitividad senos **secreciones de seno**: claro blanco Amarillo verde
☐ breast lumps/masses ☐ breast fullness/swelling ☐ black ☐ blood ☐ watery ☐ thin ☐ thick
masas/butos en senos inchazon/llenura en senos Negro sangre aguado fino grueso
☐ history of breast cancer ☐ breast pain other:
historial cancer seno dolor senos otros:

INFERTILITY (Please explain with as much detail as possible) INFERTILIDA (FAVOR DE EXPLICAR)

How long have you been trying to get pregnant?/ Cuanto tiempo lleva intentando embarazaese? _____
Have you tried any method of assisted reproduction?/ Ha intentado algun metado reproduccion asistida? _____
Any long term exposure to chemicals?/**Exposicion cronica a substancias quimicas**? _____
Do you keep track of you menstrual cycle?/ Mantiene calendario de su periodo? _____
Do you keep your BBT(Basal Body Temperature)?/Lleva cuenta de su temperature basal corporal? _____

Do you test yourself for ovulation?/Se autoexamina para ovulacion_?_____
Has your partner been evaluated for infertility?Ha sido su pareja examinado para infertilidad?_____
Anything else you would like to tell us?/Desea compartir cualquier otra informacion? _____

FLORIDA COLLEGE OF INTEGRATIVE MEDICINE
PATIENT INFORMATION FORM

Date _____

Name _____ Last 4 digits of Social Security #

_____

Birth Date_____ Age_____ Marital Status_____ Gender: M_____ F_____

Address _____ City _____ State _____ Zip

_____

Primary Phone Number _____ [ ] Home [ ] Mobile [ ] Work

Secondary Phone Number _____ [ ] Home [ ] Mobile [ ] Work

e-mail address: _____

Please check *one* of the following:

_____ It is permissible to call and/or leave a detailed message.

_____ DO NOT CALL

Place of Employment _____ Occupation

_____

Address _____ City _____ State _____ Zip

_____
Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name _____ Telephone Number
_____

Name _____ Telephone Number
_____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

Name _____ Telephone Number
_____

Name _____ Telephone Number
_____

[ ] I do wish to have this information disclosed.

How were you referred to the Clinic? _____

It is the responsibility of the patient to notify the Florida College of Integrative Medicine if any of their information should change. Please inform the front desk of any changes, so that we may update your records.

_____
_____
PRINT Patient Name DATE

_____
Patient Signature

NATIONAL INSTITUTE of ORIENTAL MEDICINE
dba **Florida College of Integrative Medicine**
7100 Lake Ellenor Drive, Orlando, Fl 32809-5721
Phone: (407) 888-8689 x10 Fax: (407) 888-8211

I hereby consent to the following provisions deemed necessary by NATIONAL INSTITUTE of ORIENTAL MEDICINE (NIOM) *dba* **FLORIDA COLLEGE OF INTEGRATIVE MEDICINE (FCIM)**:

Patient's Name: (PLEASE PRINT): _____

A. Treatment: Any and all health care and treatment, which may include acupuncture, herbal formulas, TuiNa, cupping therapy, moxibustion, therapeutic exercises and/or nutritional counseling. I understand that needling and cupping therapy may cause bruising in some cases.

B. Financial information: All professional fees are due in full at the time services are rendered. I hereby acknowledge and accept full responsibility for any and all costs incurred. NIOM *dba* **FLORIDA COLLEGE OF INTEGRATIVE MEDICINE does not bill insurance or other third-party payers.** Therefore, it is my sole responsibility to request reimbursement from my health insurance plan if I desire reimbursement of costs paid.

C. Authorization of Compensation: Payment is made directly to NIOM *dba* **FLORIDA COLLEGE OF INTEGRATIVE MEDICINE** for the amount due after services have been rendered. Payment can be made by major credit cards or cash.

D. Authorization to Use and Disclose Health Information: I authorize **FLORIDA COLLEGE OF INTEGRATIVE MEDICINE** to use all of my medical data for educational purposes or in cases of disputed credit card transactions. **Confidentiality will be maintained.**

I authorize the release of any of my medical information to my insurance company for the purpose of assessing claims. This information includes records of examination, diagnosis, treatment and billing information during the duration of care. Unless revoked earlier, this authorization will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____
(**FCIM** REPRESENTATIVE)

FLORIDA COLLEGE OF INTEGRATIVE MEDICINE
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____ Date: _____

Printed Name of Patient *or* Patient's Representative

Relationship to Patient (only if other than patient): _____

Witness: _____ Date: _____

Printed Name of FCIM Representative