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:

OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:
Exposiciones peligrosas ambientales/Trabajo:

Chemical: _____ Acid/Alkalines: _____
Quimicas: Acido/Alcalinos
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
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
☐ 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
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
eight ☐ sleep walking
sonambulo
☐ 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
suplementos

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/
Dedica tiempo paraa relajarce/meditar
prayer? ☐ yes ☐ no
nuves mentales coordinacion pobre
Hierbas Reza si no

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
☐ eczema
eczema
Skin: ☐ dry ☐ moist
Piel: seca humeda
☐ sores
aftas
☐ ulcers
ulceras
☐ herpes
herpes

☐ psoriasis
soriasis
☐ eruptions
erupsiones
☐ discharge
supuraciones
☐ pimples/acne
acne
☐ bruises
trauma
☐ hives
errupcion/alergias

☐ itching
picor
☐ fungal/yeast infection
Hongo/ inf de levadura
☐ change in skin texture
cambio en la textura
☐ dandruff
caspa
☐ loss of hair
perdida de cabello
☐ balding
calvicie

☐ thinning of hair
Perdida de cabello
☐ change in hair
cambio en el cabello
☐ other hair problems:
otros problemas de cabello
_____
☐ other skin problems:
otros problemas de piel
_____

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
☐ dizziness
mareos
☐ migraine
migranas
Headaches:
Dolor de cabza:
☐ frontal
frontal
☐ temporal
temporal
☐ vertex
vortex
☐ occipital
occipital
☐ head injury
trauma de cabeza
☐ facial pain
dolor facial
☐ facial paralysis
paralysis facial
☐ sinus problems
problema de sinositis
☐heaviness in head
pesades de cabeza

Eyes (R/L) / Hojos(D/I)
☐ cataract/
catarata
☐ glaucoma
glaucoma
☐ eye pain
dolor de ojo
☐ twitching
mov imvoluntario
☐ floaters/spots
flotantes
☐ poor vision
pobre vision
☐ blurry vision
vision borroza
☐ night blindness
seguera nocturna
☐ itchiness
picor
☐ glasses/contacts
espejuelos/contactos
☐ red eyes
hojos rojo
other:_____
otros

Ears (R/L) / Oidos (D/I)
☐ loss of hearing
perdida de audicion
☐ discharge
secreciones
☐ earaches
dolor de oido
☐ poor hearing
audicion pobre
☐ itchiness
picor
Ringing in ears:
Ruidos en el oido:
☐ loud ☐ soft
alto suave
☐ high pitch
ruido alto
☐ low pitch
tono bajo
☐ inflammation
inflamacion
☐ tenderness
sensitividad
other:_____
otros

Nose / Nariz
☐ loss of smell
perdida de olfato
☐ good sense of smell
buen sentido olfato
☐ nose bleeds
sangramientos nasals
☐ allergies
alergias
☐ nasal discharge
secrecion nasal
color: ☐ yellow
color: Amarillo
☐ white ☐ clear
blanco claro
☐ green
verde
amount:
cantidad:
☐ mod
moderado
☐ thick
grueso
☐ dry nose
nariz seca
other / otros _____

Mouth / Boca
☐ grind teeth
rechina dientes
☐ drooling
babeo
☐ excess saliva
saliva excesiva
☐ dry mouth
sequedad bucal
☐ gum disease
enf de encias
☐ bad breath
mal aliento
☐ gum bleeding
sangre encia
☐ gum swelling
edema en la encia
☐ scanty
escaso
☐ heavy
pesado
☐ thin
fino
☐ dry lips
labios secos

Throat / Cuello
☐ dry throat
garganta seca
☐ hoarseness
cambio de voz
☐ recurrent
recurrente
☐ sore throat
dolor de garganta
☐ loss of voice
perdida de voz
☐ difficulty
dificultad
☐ swallowing
edema
☐ "lump in troat"
"bulto en garganta"
☐ taste in mouth
sabor en la boca
☐ ulcers
ulcera
☐ sores
ulceras
☐ frequent
frequencia
☐ tonsillitis
amigdalitis
☐ freq. throat
clearing
garraspera

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
☐ low blood pressure
presion baja
☐ dizziness
mareos
☐ fainting
desmayo
☐ palpitations
palpitaciones

☐ chest pain
dolor de pecho
☐ cold hands/feet
manos fria
☐ swelling hands/feet
edem manos/pies
☐ irregular heart beat
pulsaciones cardiacas irregulars
☐ insomnia
insomnia

☐ difficulty in breathing
dif en respirar
☐ shortness of breath
falta de aliento
☐ dream disturbance
pesadillas
☐ poor memory
memoria pobre
☐ mania/delirium
mania/alucinaciones

☐ coma
coma
☐ loss of consciousness
perdida de consiencia
☐ heart pounding
palpitaciones cardiacas
☐ stifling sensation in chest
pecho trancado
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 ☐ croup ☐ rapid ☐ other
seca perruda seguida otra

phlegm: ☐ thin ☐ thick ☐ clear
flema fina espeza clara
☐ white ☐ yellow ☐ green
blanca amarilla verde

☐ tightness in chest ☐ allergies
oppression en pecho alergias

☐ sinus infection ☐ post nasal drip
sinusitis goteo postnasal

☐ sinus congestion ☐ heaviness in chest
congestion nasal pesadez en pecho

☐ shortness of breath
falta de aliento

☐ fullness in chest
pesadez en el pecho

difficulty breathing:
difficultad para respirar
☐ sitting ☐ lying down
sentado 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
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 swallowing
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
Color: nuboso palido
☐ 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

☐ dribbling urine
goteo

☐ unable to urinate
incapacidad de orinar

☐ frequent urination
frequencia de miccion

☐ sexually active ?
sexualmente activo

☐ diminished sex drive
disminucion deseo sexual

☐ increased sex drive
aumento de libido

☐ impotency
impotencia

☐ genital itching
picor genital

☐ genital sores/pain
chancros genitales

☐ discharge
secreciones

☐ history of kidney stones
historial calculos renales

☐ 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
☐ depression
depresion
☐ anxiety
ansiedad
☐ easily stressed
facil de estrezarse
☐ confusion/foggy
confusion/neblura
☐ lack of clarity
falta de claridad
☐ moody
mal genio
☐ fear/fright
miedo/sustos
☐ hyper
hyperactivo
☐ sadness
tristeza
☐ frustration
frustraciones

☐ melancholy
melancolia
☐ grieving
luto/perdidi
☐ easy to anger
facil de enojar
☐ irritability
irritabilidad
☐ restlessness
inquietud
☐ emotional
emocional
☐ frequent sighing
suspiros frequentes
☐ over-worried
preocupacion exseciva
☐ bad-tempered
mal genio
☐ tics
movimiento involuntario
☐ hopelessness
desesperanza

☐ joyful
alegre
☐ giddy
se rie mucho
☐ over-thinking
piensa demasiado
☐ talkative
hablador
☐ silent
callado
☐ extrovert
extrovertido
☐ introvert
introvertido
☐ poor memory
mala memoria
☐ seizures
ataques
☐ panic
panico
☐ feeling stuck
siente que no progressa

☐ tremors/shaking
temblores
☐ convulsions
convulsiones
☐ coma
coma
☐ concussion
contusion
☐ paralysis
paralysis
☐ trauma at birth
nacimiento traumatico
☐ vaginal delivery ☐ cesarean
nacimiento vaginal cesaria
☐ considered/attempted suicide
considero/intento suicidio
☐ unable to focus
inhabilida para concentrarse
☐ phobia
fobias
☐ 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
☐ decreased libido
disminucion de libido
☐ hernia
herni
hernia
☐ infertility
infertilidad
☐ history of STD / historial de ETS

☐ swellings, lumps and pain in testicles
inchazon, bultos /dolor testicular
☐ cold feeling in genitals
sensacion genitalia fria
☐ difficult ejaculation
ejaculacion con dificultad
eyaculacion con dificultad
☐ painful erections
recciones dolorosas
☐ other/otros:_____

☐ discharge from penis
secrecion del pene
☐ difficult achieving and maintaining erection
dificultad en obtener /mantener ereccion
☐ injury to reproductive organs
organo reproductivo lastimados
lastimado organos reproductibo
☐ currently sexually active
sexualmente activo en la actualidad

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 maior 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:
pildora control de natalidad
type _____
tipo
how long? _____
cuanto tiempo?
☐ hormone replacement
remplaso hormonal

☐ age at menopause _____
edad de menopausea
☐ history of ovarian cysts
historiao quistes ovaries
☐ history of uterine problems
Historial problemas uterinos
☐ decreased libido
disminucion de libido

flow: ☐ thick ☐ thin
flujo: mucho fino
amount: ☐ scanty ☐ mod
cantidad escazos mod
☐ heavy ☐ very heavy
pesado muy pesado
☐ absent menstruation
periodo ausente

☐ vaginal burning/itching
pocor/calenture vaginal
☐ vaginal pain
dolor vaginal
☐ genital eruptions
erupciones genitales

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

☐ history of breast disease
historial de enfermedades del seno
☐ breast lumps/masses
masas/butos en senos
☐ history of breast cancer
historial cancer seno

☐ breast tenderness
sensitividad senos
☐ breast fullness/swelling
inchazon/llenura en senos
☐ breast pain
dolor senos

breast discharge: ☐ clear ☐ white ☐ yellow ☐ green
secreciones de seno: claro blanco Amarillo verde
☐ black ☐ blood ☐ watery ☐ thin ☐ thick
Negro sangre aguado fino grueso
other: _____
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. **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