MIAMI ACUPUNTURA
Patient Information Form

Date ___ / ___ / ___
MM / DD / YY

PATIENT CONFIDENTIALITY IS HIGHLY RESPECTED. ALL COMMUNICATION IN THIS DOCUMENT IS CONSIDERED CONFIDENTIAL INFORMATION IN ACCORDANCE WITH FEDERAL HIPPA REGULATIONS

First Name: _____ **Middle Name:** _____ **Last Name:** _____ **Date of Birth** ___ / ___ / ___ **Sex** ☐ F ☐ M

Address street: _____ **City:** _____ **State:** _____ **Zip code:** _____

Emergency contact: _____ **Relationship with patient:** ☐ **Spouse** ☐ **Friend** ☐ Family **Phone relationship:** _____

Insurance Information

Insurance Company: ☐ Blue Cross and Blue Shield ☐ United Health Care ☐ Avmed ☐ Aetna ☐ Cigna ☐ Medicaid ☐ Medicare

ID # _____ **Group #** _____ **Co-Pay $** _____ **Covered %** _____ **Deductible Amount** _____

Acupuncture covered ☐ **Yes** ☐ **No** **Physical therapy** ☐ **Yes** ☐ **No** **Visit #** _____

Patient consent for use and disclosure of Protected Health Information (PHI) Acknowledgment of receipt of Notice of Privacy Practices

I acknowledge that I have been provided with ***ANREY AMERICAN, LLC (Miami Acupuntura),*** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient Name: (please print) _____ _____

Patient Signature (or legal representative; proof may be requested) _____

EMAIL/TEXT MESSAGE TO Mobile Phone CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **ANREY AMERICAN, LLC., (AA)** ***(Miami Acupuntura)*** offers patients the opportunity to communicate by email/mobile text messaging.

Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **AA** will use reasonable means to protect the security and confidentiality of email/ mobile text messaging information sent and received. However**, AA** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **AA** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is: _____

My Consented for Text Messaging to (Phone): _____

MIAMI ACUPUNTURA

Consent To Treatment Form

First Name **Middle** **Last Name** **Date:** / /

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques. Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

INTRODUCING OUR SERVICES

Modalities of the Chinese Medicine used in Miami Acupuncture

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the* ANREY AMERICAN LLC *as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Date: / /

Patient Signature:

MIAMI ACUPUNTURA
Patient History Form

First Name **Middle** **Last Name** **Date:** / /

Welcome! This questionnaire is a very important diagnostic procedure for assessing your health. Please take the time to thoroughly complete this form. Your personal information will be kept confidential according to federal HIPPA regulations.

ASSESSMENT

Main reason for visit:

How long have you had this condition?. Hours. Days. Weeks. Months. Years.

Have you seen other doctors about this condition? Yes No

Have you been seen in an ER for this problem? Yes No

Does this problem interfere with your daily functioning? Yes No

Sleeping Sitting Standing Walking Personal Care Lifting Traveling

What medicines are you currently taking?

Medicine/supplements	Reason

Select all previous surgeries: None

Aneurysm (Brain) Hysterectomy Appendectomy Lumpectomy

Aortic Bypass / Vascular Surgery LAPBand/ Gastric Bypass Surgery

Cataract (Eye) Malignancy/Cancer Mastectomy Heart Surgery

What kind of treatment have you tried for this condition?

Medication Surgery Massage Therapy Acupuncture Others

Have you had any prior tests for this problem?

None X-rays MRI CT Scan Nerve Test (EMG/NCV) Bone Scan

Personal & Family Medical History (Check any following condition)

Condition	Patient	Mother	Father	Condition	Patient	Mother	Father
Allergies				Infection disease			
Asthma				Thyroid disorder			
Mental illness				Parkinson			
Seizures				Substance abuse			
Heart disease				Migraine Cancer			
Diabetes Mellitus				Depression			
Hepatitis				Anemia			

Orthopedic on side:	Right	Left
Arthroscopy: Knee		
Arthroscopy: Shoulder		
Carpal Tunnel Release		
Rotator Cuff Repair		
Total Hip Replacement		
Total Knee Replacement		
Total Shoulder Replacement		

Comments:

Do you have any allergies? Yes No

If Yes, please list below:

Medication, Relevant Food,	Reaction

Medical Questions

Mark all that currently apply:

Metal in body Claustrophobic Snores

Pregnant Uses a CPAP Sleep Apnea

Are you taking blood thinners? Yes No

DR ANICETO CABRERA
Acupuncture physician

MIAMI ACUPUNTURA
Patient History Form

First Name _____ **Middle** _____ **Last Name** _____ **Date:** __ / __ / ____

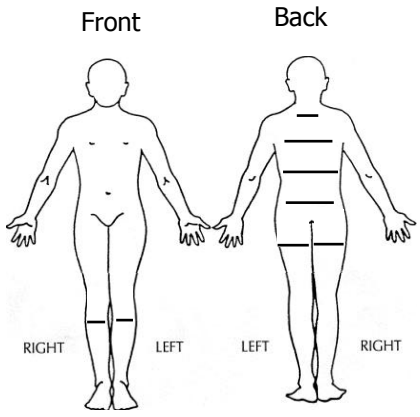
PAIN ASSESSMENT

Do you have pain? ☐ Yes ☐ No

☐ Neck Pain ☐ Upper Back ☐ Middle Back ☐ Low Back ☐ Sciatica left side ☐ Sciatica right side ☐ Tail Bone

How long do you have the pain?: ☐ Hours. ☐ Days. ☐ Weeks. ☐ Months. ☐ Years.

Shoulder	☐ Right	☐ Left		Pelvis	☐ Right	☐ Left	
Upper Arm	☐ Right	☐ Left		Hip	☐ Right	☐ Left	
Elbow	☐ Right	☐ Left		Thigh	☐ Right	☐ Left	
Forearm	☐ Right	☐ Left		Knee	☐ Right	☐ Left	
Wrist	☐ Right	☐ Left		Lower Leg	☐ Right	☐ Left	
Hand	☐ Right	☐ Left		Ankle	☐ Right	☐ Left	
Thumb	☐ Right	☐ Left		Foot	☐ Right	☐ Left	
Index	☐ Right	☐ Left		Great Toe	☐ Right	☐ Left	
Middle	☐ Right	☐ Left		2nd Digit	☐ Right	☐ Left	
Third	☐ Right	☐ Left		3rd Digit	☐ Right	☐ Left	
Little	☐ Right	☐ Left		4th Digit	☐ Right	☐ Left	
				5th Digit	☐ Right	☐ Left	



☐ Fracture ☐ Numbness/Tingling ☐ Stiffness

Modification by Pressure: ☐ Better with Pressure ☐ Worse with Pressure **Pain is worse during the:** ☐ Daytime ☐ Nighttime

Modification by Temperature: ☐ Better with Heat ☐ Worse with Heat? ☐ Better with Cold ☐ Worse with Cold?

Describe Quality of Pain: ☐ Contracting ☐ Sharp ☐ Stabbing ☐ Pinching ☐ Hidden ☐ Cramping ☐ Throbbing ☐ Dull ☐ Aching ☐ Heaviness ☐ Pushing or pulling

Timing of the pain: ☐ Comes and goes ☐ Acute ☐ Chronic **Location of Pain:** ☐ Fixed ☐ Moving ☐ Radiating

Sleeping problems for the pain No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep ☐ **Frequency of pain** 25% of time ☐ 50%of time ☐ 100% of time ☐

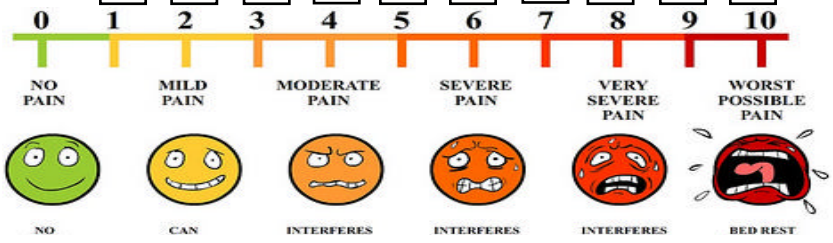
Are there any other symptoms associated with this problem?

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking ☐ Popping ☐ Tingling ☐ Weakness

What makes the symptoms worse?

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending Stairs ☐ Twisting ☐ Moving ☐ Lying in bed Running
☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead ☐ Emotional problems

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐



Use the scale to better estimate the level of the pain

DR ANICETO CABRERA
Acupuncture physician

MIAMI ACUPUNTURA
Patient History Form

First Name **Middle** **Last Name** **Date:** / /

Social History

Marital Status: Married Single Divorced Widowed Domestic Partnership Are you currently working? Yes No

Retired Disabled If no, what date did you last work? Please list work restrictions, if any:

Occupation: Employer: Student:

Personal Medical History:

General Symptoms: **None for all**

- Poor appetite
- Heavy appetite
- Weight loss/gain
- Heavy sleep
- Dream-disturbed sleep
- Poor sleep
- Cold hands or feet
- Night sweats
- Sweat easily
- Bleed or bruise easily
- Vertigo or dizziness
- Poor circulation
- Lack of strength
- Chills
- Fever

Comment:

Eyes, ears, nose, mouth and throat symptoms: **None for all**

- Glasses
- Cataract
- Red eyes
- Blurred vision
- Night blindness
- Glaucoma
- Sinus problems
- Teeth problems
- Grinding teeth
- Gum problems
- Sores on lips
- Sores on tongue
- Earaches
- Nosebleeds
- Ringing in ears
- Dry throat
- Poor sense of taste
- Poor sense of smell

Comment:

Respiratory symptoms: **None for all**

- Shortness of breath
- Cough
- Sinus problems
- Nasal Bleeding
- Tight chest
- Coughing up blood

Comment:

Cardiovascular symptoms: **None for all**

- High blood pressure
- Blood clots
- Heart palpitations
- Phlebitis
- Feelings of Cold
- Cold limbs
- Water retention
- Varicose veins
- Rheumatic fever
- Chest pain
- Heart murmurs
- Swelling of feet
- Pace marker

Comment:

Gastrointestinal symptoms: **None for all**

- Nausea
- Acid regurgitation
- Difficulty swallowing
- Diarrhea
- Constipation
- Weight gain
- Colitis
- Gall stones
- Itchy anus
- Bloating
- Mucous in stools
- Vomiting
- Liver disease
- Weight loss
- Hemorrhoids
- Motion sickness
- Hepatitis B or C
- Colon problems
- Bloody stool
- Black stools
- Bad breath

Comment:

Musculoskeletal symptoms: **None for all**

- Cervical pain
- Upper back pain
- Lower back pain
- Sciatic pain
- Thoracic pain
- Rib pain
- Hip pain
- Herniated disc
- Shoulder pain
- Hand pain
- Elbow pain
- Wrist pain
- Knee pain
- Foot pain
- Ankle pain
- Carpal Tunel
- Osteoporosis
- Broken bone(s)
- Fibromyalgia
- Decreased range of motion
- Arthritis

Comment:

DR ANICETO CABRERA
Acupuncture physician

MIAMI ACUPUNTURA
Patient History Form

Skin and Hair symptoms: ☐ **None for all** ☐ Easily bruised ☐ Sores that don't heal ☐ Hair loss

☐ Hives ☐ Ulcerations ☐ Jaundice ☐ Eczema ☐ Psoriasis ☐ Acne ☐ Rashes ☐ Fungal infection ☐ Itching

Comment: _____

Neuro-psycological symptoms: ☐ **None for all**

☐ Tics	☐ Tingling	☐ Depression	☐ Insomnia
☐ Numbness	☐ Poor coordination	☐ Easily angered	☐ Difficulty falling asleep
☐ Headache	☐ Poor memory Poor	☐ Panic Attack	☐ Difficulty staying asleep
☐ Tremors	☐ concentration	☐ Obsessive thoughts	☐ Considered/attempted suicide
☐ Seizures	☐ Muscle weakness	☐ Treated for emotional problems	☐ Worry/anxiety

Comment: _____

Genitourinary symptoms: ☐ **None for all**

☐ Painful urination	☐ Unable to hold urine	☐ Blood in urine	☐ Decreased libido
☐ Frequent urination	☐ Incomplete urination	☐ Increased libido	☐ Impotence
☐ Urgent urination	☐ Bedwetting	☐ Premature ejaculation	☐ Waking up to urinate

How many times do you urinate per 24 hours Qualities of the urine ☐ Yellow ☐ Cloudy ☐ Copious ☐ Scanty ☐ Clear

Comment: _____

Male concerns: ☐ **None for all** ☐ Nocturnal emission ☐ Infertility

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Impotence

Comment: _____

Gynecology symptoms: # Pregnancies Age of menopause

☐ Vaginal discharge ☐ Vaginal sores ☐ Vaginal (odor) ☐ Vaginal bleeding after sex ☐ Anorgasmia ☐ Painful intercourse

☐ Infertility ☐ Cervicitis ☐ Painful periods ☐ Breast lumps ☐ Fibroma ☐ Chronic pelvic pain ☐ Clots

Age at 1st menses Length of cycle (days Duration of flow (days) Are you pregnancy ?

☐ Light flow ☐ Heavy flow Last menses date: # Live birth # Premature births # Abortion

Comment: _____

Endocrine problems: ☐ **Yes** ☐ **No**

☐ Diabetes mellitus type I ☐ Diabetes mellitus type II ☐ Hypothyroidism ☐ Hyperthyroidism

Comment: _____

Lifestyle (Check any following condition) Stress Level (1-10) ☐

☐ Soda. How many cups per day? ☐

☐ Coffe. How many drinks per day? ☐

☐ Marijuana ☐

☐ Recreational Drugs ☐

Do you drink alcohol?

☐ Daily
☐ Occasionally
☐ Rarely

Do you smoke tobacco?

☐ Current, every day smoker ☐ Never
☐ Current, some day smoker ☐ Former smoker
☐ Heavy tobacco smoker ☐ Light tobacco smoker

☐ Exercises ☐ Occupational hazards

On a scale from 1-10, how committed are you to correcting your problem(s)?

☐ not committed ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☑ 10 very committed

I understand the information I provided on this questionnaire is essential to determine my health and treatment needs. I have read and understood each question and certify it to be true and correct to the best of my knowledge and belief and hereby grant authorization for treatment, in accordance with state statutes, for the care and management of this complaint.

PATIENT'S SIGNATURE _____

(PARENT'S SIGNATURE IF PATIENT IS A MINOR

DR ANICETO CABRERA
Acupuncture physician

MIAMI ACUPUNTURA
Initial Evaluation

First Name **Middle** **Last Name** **Date:** / /

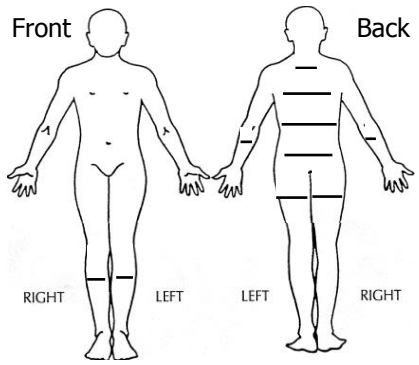
Main reason for the visit today:

Medical History:
The patient refers

PAIN ASSESSMENT.

☐ Neck pain ☐ Upper back ☐ Mid Back ☐ Lower Back Pain ☐ Sciatica left side ☐ Sciatica right side

Shoulder	Right ☐	Left ☐	Pelvis	Righ ☐	Left ☐		
Upper Arm	Right ☐	Left ☐	Hip	Righ ☐	Left ☐		
Elbow	Right ☐	Left ☐	Thigh	Righ ☐	Left ☐		
Forearm	Right ☐	Left ☐	Knee	Righ ☐	Left ☐		
Wrist	Right ☐	Left ☐	Lower Leg	Righ ☐	Left ☐		
Hand	Right ☐	Left ☐	Ankle	Righ ☐	Left ☐		
Thumb	Right ☐	Left ☐	Foot	Righ ☐	Left ☐		
Index	Right ☐	Left ☐	Great Toe	Righ ☐	Left ☐		
Middle	Right ☐	Left ☐	2nd Digit	Righ ☐	Left ☐		
Third	Right ☐	Left ☐	3rd Digit	Righ ☐	Left ☐		
Little	Right ☐	Left ☐	4th Digit	Righ ☐	Left ☐		
			5th Digit	Righ ☐	Left ☐		



☐ Numbness/Tingling ☐ Stiffness ☐ Fracture

Level of the pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pulse: ☐ Superficial ☐ Deep ☐ Rapid ☐ Slow ☐ Full ☐ Empty ☐ Slippery ☐ Wiry ☐ Irregular

Other pulse:

Tongue Body: ☐ Teeth mark ☐ Puffy

Tongue color: ☐ Normal ☐ Red ☐ Pale ☐ Purplish ☐ Red Tip ☐ Dry tongue

Tongue coating ☐ Thick ☐ Thin ☐ White ☐ Yellow ☐ Gray ☐ Greasy

Heart rate: x min Blood Pressure: / mm/Hg

Pattern: 1-

Western medical diagnosis:

Assessment :

☐ Greatly improved ☑ Improved ☐ Slightly Improved ☐ No Change ☐ Condition Worsened

Plan: ☐ Anxiety / Stress Relief ☐ Sleep well ☐ Regulate Blood sugar level ☐ Regulate Blood pressure levels ☐ Immune Support ☐ Return to normal occupational

☑ Alleviate pain ☑ Reduce inflammation ☑ Increase ROM ☑ Increase functional capacity

☐ Strength ☐ Coordination ☐ Endurance ☐ Recondition ☑ Decrease muscular spasm

☑ Avoid weight lifting and excessive physical work Other plan:

MIAMI ACUPUNTURA

Initial Evaluation

First Name _____ **Middle** _____ **Last Name** _____ **Date:** ___ / ___ / ____

ICD10: Treatment Modalities:

Method (T=tonify; D=disperse; E=even, EAC=electrical stimulation)	1unit	2units
☑ 97026 Infrared /electromagnetic radiation: (1 unit) ☐ Moxibustion	☑	☐
☐ 97010 Hot and Cold pack Therapy (Hydro Therapy)	☐	☐
☐ G0283 (United HC) 97014 ☐ Elect stimulation(unattendend) (1 unit)	☐	☐
☐ 97032 Electrical stimulation (manual)	☐	☐
☐ 97140 Manual Therapy ☐ trigger points ☐ acupressure	☐	☐
☑ 97124 Basic Swedish Massage	☐	☑
☐ 97110 Therapeutic active active assisted passive Isokinetic 15 min exercises	☐	☐
☐ 97112 Neuromuscular Therapy	☐	☐
☐ 97012 Traction mechanical, table pneumatic device (1 unit)	☐	☐
☑ 97016 Cupping	☑	☐
☐ 97810 Acupuncture	☐	☐
☐ 97811 Acupuncture	☐	☐
☑ 97813 Electroacupuncture	☑	☐
☐ 97814 Electroacupuncture	☐	☐
☐ 20505 Injection Single	☐	☐
☐ 20552 Inject one/two sites	☐	☐
☑ Auriculotherapy ☐ Paraffin ☑ Hot stone massage ☑ Laser		

Others: _____

Acupuncture Treatment: _____

Auriculotherapy Treatment: _____

Herbal medicine Formula: _____

Homeopathy _____

Phase of care: ☑ Acute ☐ Repair ☐ Rehabilitation ☐ Exacerbation

Patient currently being seen: ☐ 3x/week ☑ 2x/week ☐ 1x/week ☐ other _____

Today´s Response to the Treatment was: ☐ Excellent ☑ Good ☐ Fair ☐ Poor

Comments: _____

NPI: 1689963761 **Provider Signature** ANACETO CABRERA

MIAMI ACUPUNTURA

Visit Signature and Payment

First Name **Middle** **Last Name** **Date:** / /

Pattern:

Western medical diagnosis:

Plan: Acupuncture and Massage x 85

	Date	Payment for Acupunct	Payment for Product	Product Purchased Name	Payment Laborat	Payment EKG	Total Payment	Due	Signature
1	/ /								
2	/ /								
3	/ /								
4	/ /								
5	/ /								
6	/ /								
7	/ /								
8	/ /								
9	/ /								
10	/ /								
11	/ /								
12	/ /								
13	/ /								
14	/ /								
15	/ /								
16	/ /								
17	/ /								
18	/ /								
19	/ /								
20	/ /								

NOTE:

NPI: 1689963761

Provider Signature ANACETO CABRERA

MIAMI ACUPUNTURA
Complementary Test

First Name _____ **Middle** _____ **Last Name** _____ **Date:** __ / __ / ____

☐	**Profile 1** **CMP, Lipid Profile, CBC, TSH, Urinalysis**	**$30.00**
☐	**Profile 2** **CMP, Lipid Profile, CBC, TSH**	**$30.00**
☐	**Profile 3** **CMP, Lipid Profile, CBC, PTT, TSH**	**$30.00**
☐	**Profile 4** **CMP, Lipid Profile, CBC, TSH, Glycohemoglobin**	**$35.00**
☐	**Profile 5** **CMP, Lipid Profile, CBC, PTT, Amylase, Lipase, TSH, H. Pylory**	**$35.00**
☐	**Profile 6** **CMP, Lipid Profile, Glycohemoglobin, Microalbumin, Insulin**	**$45.00**
☐	**Profile 7** **ANA, Sed rate, Rheumatoid factor, Uric Acid, C-Reactive Protein, ASO**	**$35.00**
☐	**Profile 8** **H. Pilory, Amylase, Lipase, CBC**	**$50.00**
☐	**Profile 9** **FSH, LH, Prolactin, Estradiol, Progesterone**	**$75.00**
☐	**Profile 10** **FSH, Prolactin, Testosterone, Testosterone free**	**$95.00**
☐	**Prediabetic** **Insulin, Glycohemoglobin, TSH, Glucose 2PP, Lipid Profile**	**$85.00**
☐	**Immigration Profile** **HIV, RPR**	**$30.00**
☐	**Titers** **MMR, Varicell A, Measles, Drug screen 5 test**	**$150.00**
☐	**Titers II** **MMR, varicela, Measles, Drug screen 10 test, Hepatitis B, AB**	**$180.00**
☐	**Electrocardiogram**	**$45.00**

NPI: 1689963761
Provider Signature ANACLETO CABRERA

MIAMI ACUPUNTURA
Patient Progress Note

First Name **Middle** **Last Name** **Date:** / /

Chief Complaint

☐ Neck pain ☐ Upper back ☐ Mid Back ☐ Lower Back Pain ☐ Tail Bone ☐ Sciatica left side ☐ Sciatica right side

Shoulder	☐ Right	☐ Left	Pelvis	☐ Right	☐ Left
Upper Arm	☐ Right	☐ Left	Hip	☐ Right	☐ Left
Elbow	☐ Right	☐ Left	Thigh	☐ Right	☐ Left
Forearm	☐ Right	☐ Left	Knee	☐ Right	☐ Left
Wrist	☐ Right	☐ Left	Lower Leg	☐ Right	☐ Left
Hand	☐ Right	☐ Left	Ankle	☐ Right	☐ Left
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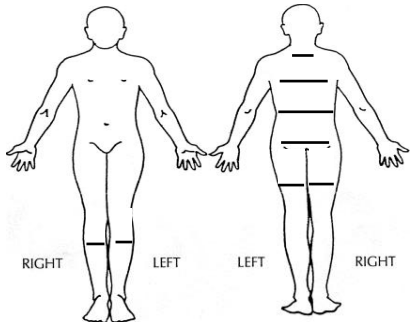
Little	☐ Right	☐ Left	4th Digit	☐ Right	☐ Left
			5th Digit	☐ Right	☐ Left



Level of the pain ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pulse: ☐ Superficial ☐ Deep ☐ Rapid ☐ Slow ☐ Full ☐ Empty ☐ Slippery ☐ Wiry ☐ Irregular

Other pulse:

Tongue Body: ☐ Teeth mark ☐ Puffy ☐ Dry tongue

Tongue color: ☐ Normal ☐ Red ☐ Pale ☐ Purplish ☐ Red Tip

Other tongue:

Tongue coating: ☐ Thick ☐ Thin ☐ White ☐ Yellow ☐ Gray ☐ Greasy

Heart rate: x min Blood Pressure: / mm/Hg

Pattern:

Acupuncture: Treatment:

Auriculotherapy: Treatment:

Herbal medicine / Formula: Formula:

Homeopathy:

Massage:

Assessment:

Phase of care: ☑ Acute ☐ Repair ☐ Rehabilitation ☐ Exacerbation

☐ Greatly improved ☑ Improved ☐ Slightly Improved ☐ No Change ☐ Condition Worsened

Plan: ☐ Anxiety / Stress Relief ☐ Sleep well ☐ Regulate Blood sugar level ☐ Regulate Blood pressure levels ☐ Immune Support ☐ Return to normal occupational

☑ Alleviate pain ☑ Reduce inflammation ☑ Increase ROM ☑ Increase functional capacity

☐ Strength ☐ Coordination ☐ Endurance ☐ Recondition ☑ Decrease muscular spasm

☑ Avoid weight lifting and excessive physical work Other:

Patient currently being seen: ☐ 3x/week ☑ 2x/week ☐ 1x/week ☐ other

Today´s Response to the Treatment was: ☐ Excellent ☑ Good ☐ Fair ☐ Poor

Comments:

Provider Signature NPI: 1689963761 ANACLETO CABRERA