Have your symptoms lasted 3 or more months? Yes_____ No_____

1. Have you ever had or now have:			2. Have you ever had or now have:				
Yes	**No**	**Please Check each item – no blanks**	**CARDIOVASCULAR**	**Yes**	**No**	**Often**	**Seldom**
		1. Chronic or frequent colds	1. Shortness of breath with normal activity				
		2. Sinusitis	2. Ankle swelling				
		3. Heart Condition	3. High blood pressure				
		4. Stomach, Liver, or intestinal trouble	4. Rapid heartbeat				
		5. Gallbladder trouble or Gall stones	5. Irregular heartbeat				
		6. Jaundice	6. Dizziness				
		7. Tumor, growth, cyst, cancer	7. Fainting spells				
		8. Venereal disease	8. Chest pain or pressure				
		9. Ear, eye, nose, throat trouble	**9. Do you have a Pacemaker?**				
		10. Drug , alcohol abuse	**RESPIRATORY**				
Female Issues: A. Have you ever:			1. Cough				
		1. Been pregnant	2. Cough up blood				
		2. Had chronic yeast problems	3. Frequent sore throat				
		3. Been treated for female disorders	4. Hoarseness				
		4. Had painful menstruation	5. Frequent sneezing				
		5. Had irregular menstruation	6. Hay fever				
B. Complete the following			7. Nose bleeds				
		1. Age of onset of menstruation	8. Asthmatic wheezing				
		2. Interval between periods	9. Pneumonia				
		3. Duration of periods	**GASTRO-INTESTINAL**				
		4. Date of last period	1. Indigestion				
Quantity: Normal____Excessive___Scanty____			2. Abdominal pain or cramps				
MEDICATIONS CURRENTLY TAKING			3. Constipation				
Prescription's Name		**Reason for medication**	4. Diarrhea				
			5. Increased thirst				
			6. Decreased appetite				
			7. Nausea and vomiting				
			8. Undigested food in stool				
			9. Bloating after eating				
			10. Excessive gas				
			11. Acid reflux				
			12. Blood in bowel movement				

Have you been prescribed and EpiPen by your Doctor? _____Yes _____No

Please check all items. No blank spaces please..				
Skin	**Yes**	**No**	**Often**	**Seldom**
1. Ulcerations				
2. Itching				
3. Rash				
4. Psoriasis				
5. Long Term Dry Skin				
6. Frequent Boils				
GENITO-URINARY				
1. Frequent urination				
2. Painful, burning urination				
3. Pain in the testicle				
4. Bloody or other discharge				
5. Loss of sexual potency or desire				
6. Cold feeling in the genital area				
MUSCLE-SKELETAL				
1. Arthritis				
2. Rheumatoid Arthritis				
3. Muscle pain or cramps				
4.Painful joints				
5. Lameness				
6. Backaches				
7. Back Pain				
MISCELLANEOUS				
1. Fever				
2. Chills				
3. Night sweats				
4. Headaches				
5. Insomnia				
6. Nervousness				
7. Easy Fatigability				
8. Frequent Irritability				
9. Morning Tiredness				
10. Tremors or uncontrollable shaking				
11. Nightmares				

Do you have or have you had recently:	Yes	No	Is there a family history of:	Yes	No
1. Weight loss: How much?_____			1. Tuberculosis		
2. Weight gain: How much?_____			**2. Diabetes**		
3. Memory loss			3. Cancer		
4. Difficulty walking in the dark			4. Multiple sclerosis		
5. Balance problems			5. Chron's syndrome		
6. Numbness & tingling in the extremities			6. Irritable bowl syndrome		
7. Hearing loss			7. Heart trouble		
8. Ringing in the ears			**8. High blood pressure**		
9. Vision change			9. Asthma, hay fever, hives		
10. Double vision			**10. Systemic Mastocytosis**		
11. Earaches			11. Stroke		
12. Running ears			12. Gout		
13. Tendency to bleed or bruise easily			13. Alzheimer's disease		
14. Heat intolerance			14. Downs syndrome		
15. Cold intolerance			15. Myasthenia Gravis		
16. Lymph node enlargement			16. Celia Sprue		

ARE YOU ALLERGIC TO ANY TYPE OF FOOD? IF SO, WHICH?	**Please list all operations & your age when each was performed**
HOW OFTEN DO YOU EXERCISE?	**NAME THE MOST RECENT SELF-HELP BOOK THAT YOU'VE READ:**
PLEASE LIST ALL VITAMINS AND SUPPLEMENTS CURRENTLY TAKING:	**WHICH OF THE FOLLOWING THERAPIES HAVE YOU BEEN TREATED WITH IN THE PAST?**

ACUPUNCTURE		MASSAGE	
CHIROPRACTIC		HYPNOSIS	
HERBAL MEDICINE		HOMEOPATHY	
CHINESE HERBS		OTHER	

INFORMED CONSENT TO ACUPUNCTURE MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named above, for whom I am legally responsible) by Fernando Bernall, DOM, AP

1. Acupuncture and other Oriental Medical procedures including diagnostic techniques such as questioning, pulse evaluation, tongue evaluation, abdominal evaluation, observation, range of motion, muscle or orthopedic testing.
2. Manual therapy including cupping, Tuina, electrical stimulation, infrared heat therapy, trigger point therapy, motor point therapy, dry needling therapy, acupuncture injection therapy, gua sha, nutritional counseling, biopuncture.
3. The prescription of herbal therapy, dietary supplements, dietary recommendations
4. Exercise advice and healthy lifestyle counseling.
5. I have had an opportunity to discuss with Fernando Bernall, DOM, the nature and purpose of acupuncture, acupoint injection therapy, and Chinese Medicine. Although I am aware that Acupuncture and the other Chinese Medicine procedures have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.
6. I understand and am informed that, as in the practice of allopathic medicine, in the practice of acupuncture, acupuncture injection therapy, and Chinese medicine there are some risks to treatment.
7. I understand that although these risks are highly unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of needle insertion or radiating from that location, nerve pain, aggravation of current symptoms (healing crisis), appearance of new symptoms, or general aches and pains.
8. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist's judgment during the course of my treatment.
9. I have read (or had read to me) this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Fernando Bernall, DOM, AP.
10. I UNDERSTAND THAT IF I AM BEING TREATED FOR SMOKING CESSATION, AND CHOSE TO STOP TREATMENT AND CONTINUE TO SMOKE, THAT THERE ARE NO REFUNDS.

BEFORE YOU SIGN: BY SIGNING BELOW, YOU AGREE TO NOT GET ME INVOLVED WITH ANY INSURANCE DISPUTES, ATTORNEYS, ETC. I'M HERE TO HELP YOU WITH YOUR CONDITION. I'M A ONE MAN PRACTICE AND HAVE NO TIME FOR LEGAL PROCEDURES, DEPOSITIONS, SUBMITTING RECORDS, AND SIMILAR MATTERS. THANK YOU FOR YOUR UNDERSTANDING.

_____ _____

31 Patient's Signature Date

Fernando Bernall, DOM, AP

88 Riberia Street #250 • Saint Augustine, Florida 32084 • Phone: 904-806-7123
E-Mail: fbernall@yahoo.com Web: www.FernandoBernall.com

Please keep this page for your records. Fee Schedule Effective January-2018

Initial Evaluation without treatment		$125.00
Initial evaluation with treatment		$165.00
Follow up sessions with acupuncture treatment		$90.00
Acupuncture follow up treatment w/estim: (97813/97814)		$115.00
Manual Therapy: (97140)	Per unit (15)	$50.00
Heat therapy (97010)		$40.00
Vasopneumatic devices / Cupping (97016)		$40.00
Infrared Therapy (97026)		$40.00
Pain Injections: (20552)	With Acupuncture	$40.00
	Without Acupuncture	$75.00
Trigger Point and Motor Point Acupuncture		$140.00
Initial Functional Medicine Consultation (90 minutes)		$195.00

B-12 and B-6 INJECTIONS OPTIONS:

Methylcobalamin (B-12):	$30 per injection (package of 10 for $250.00)
Pyridoxine (B-6)	$30 per injection (package of 10 for $250.00)
Fat Burner Lipotropic Injection:	$35 per injection (package of 10 for $300.00)