PATIENT LAST NAME: ___________________________________ **FIRST:** ________________________

ADDRESS: ___________________________________CITY: ______________STATE_____ZIP ________

DATE OF BIRTH:______/__________/______ AGE _______________SEX________ F ____ M _______
M D Y

CELL PHONE:____________________________ HOME PHONE: _______________________________

WORK PHONE: _________________________________ EMAIL: _______________________________

SOCIAL SECURITY# ___________________________MARITAL STATUS_______________________

EMPLOYER____
(NAME) (ADDRESS) (CITY/ST/ZIP)

RESPONSIBLE PARTY(LAST)____(FIRST)_______________________

ADDRESS_________________________________CITY________________STATE______ZIP_______

HOME PHONE_____________________CELL______________________________

DATE OF BIRTH___________________________AGE__________SEX_________F_____M__ ______

SOCIAL SECURITY NUMBER___________________________MARTIAL STATUS_________________

PRIMARY INSURACE INFORMATION

____
(Primary Insurance Company Name) (ID#) (Group #)

____
(Address) (City, State, Zip Code) (Phone)

____
(Policy Holder Name) (ID#) (Date of Birth)

EMERGENCY CONTACT INFORMATION

____
(Name) (Phone) (Relationship)

____
(Address) (City) (State) (Zip)

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

X____
Patient/Responsible Party Signature Date

AGREEMENT TO PAY FOR TREATMENT

Holistic Care Solutions
1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

Patient's Name: ____

I, THE RESPONSIBLE PARTY LISTED BELOW, HEREBY AGREE TO PAY ALL CHARGES SUBMITTED BY THIS OFFICE DURING THE COURSE OF TREATMENT FOR THE PATIENT.

If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, I agree to pay all applicable co-payment and deductibles which arise during the course of treatment for the patient. Co-pays are expected to be paid at the time of service. The responsible party also agrees to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers or payors.

"No show Policy" - If a patient makes an appointment and fails to show up or cancel the appointment at least one hour in advance they will be considered a "no show" for that visit. Insured patients who have two "no show" visits at the clinic will be charged a $25.00 no show fee for every "no show" thereafter. This will not be paid by insurance and is the patients' responsibility. We have adopted this policy in an effort to be able to see sick patients as quickly as possible.

Check policy - All bounced checks to Alpine Family Practice will be retrieved through electronic payment systems. There will be a fee to the patient for this recovery service.

Collection Policy – If a patient is sent to collections for failure to make payment or if patient declares bankruptcy they will be expected to pay all charges in advance at future appointments. If a patient is sent to collections a second time they (and anyone they are financially responsible for) will be dismissed from the clinic.

X____

Patient / Responsible Party Signature Date

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

Holistic Care Solutions
1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

Patient's Name: ____

I, understand responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize the office and/or its employees to release, via fax machine, medical records which are needed in ordered to provide the patient with the most appropriate medical care.

I, authorize and request the payment of my third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X____
Patient / Responsible Party Signature   Date

GENERAL CONSENT TO TREATMENT

Holistic Care Solutions
1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

Patient's Name: ____________________________________

By signing below, I (or my authorized representative on my behalf) authorize Holistic Care Solutions physicians, practitioners and their staff to conduct any diagnostic examinations, tests or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and
anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of holistic medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

X____

Patient / Responsible Party Signature   Date

AVISO SOBRE LAS PRACTICAS DE PRIVACIDAD
RECONOCIMIENTO DE RECIBO

Holistic Care Solutions
1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

FECHA: ______________________

Reconozco que se me proporcionó una copia del Aviso sobre las Prácticas de Privacidad de Holistic Care Solutions.

____
Nombre del Paciente (en letras de imprenta)

____
Firma del paciente

Si este formulario fue completado por el representante personal del paciente, por favor escriba el nombre en letras de imprenta y firme a continuación.

____________________________________	______________________________
Nombre del Representante Personal	Firma del representante personal

Este formulario se debe colocar en el expediente médico del paciente

Receipt of Patients' Rights and Responsibilities
Written Acknowledgement Form

Holistic Care Solutions

1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

I______________________________, have reviewed/received a copy of Dr. Emilia Cabrera's Patient's Rights and Responsibilities.

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving health services.

X____
Patient / Responsible Party Signature   Date

FOR OFFICE ONLY

I attempted to obtain a patient's signature in acknowledgement of this, Patient's Bill of Rights and Responsibilities but was unable to do so. Documented below.

Date: ____________   Initials: ________   Signature: _____________

Reason:
____
____
____

THIS COPY IS FOR YOU PATIENT

PATIENT BILL OF RIGHTS

Holistic Care Solutions
1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

Medical privacy or **health privacy** is the practice of keeping information about a patient confidential. This involves both conversational discretion on the part of health care providers, and the security of medical records. The terms can also refer to the physical privacy of patients from other patients and providers while in a medical facility. Modern concerns include the degree of disclosure to insurance companies, employers, and other third parties.

Patients have the right to control who will see their protected, identifiable health information. Communications with or about patients involving patient health information will be private and limited to those who need the information for treatment, payment, and healthcare operations. Such communications may involve verbal discussions and written communications. Only those people with an authorized need to know will have access to the protected information.

Confidential information includes patient identity, address, age, Social Security number, and any other personal information that patients are asked to provide.

Confidential information also includes the reason a person is sick the treatments, medications that he or she may receive, and other observations about his or her condition or past health conditions.

We are committed to protecting patient privacy and confidentiality in the following ways:
Patient care or discussion about patient care is kept private by closing doors or conducting them in an area where the discussion will not be overheard.
Patient medical records are not left where others can see them or gain access to them
Written patient information is kept covered from the public
Diagnostic tests results are kept private
Paper records no longer needed are shredded or placed in closed receptacles for disposal. They are not left in the garbage.

Information is not disclosed to visitors about a patient

HOLISTIC CARE SOLUTIONS
DR. EMILIA CABRERA

PACIENTE, ESTA INFORMACION ES PARA USTED

TRATO DE CONFIDENCIALIDAD AL PACIENTE

Holistic Care Solutions
1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

Estamos obligados por ley a mantener la privacidad y seguridad de su información médica protegida.

Le haremos saber de inmediato si ocurre un incumplimiento que pueda haber comprometido la privacidad o seguridad de su información.

Debemos seguir los deberes y prácticas de privacidad descritas en esta notificación y entregarle una copia de la misma.

Cuando se trata de su información médica, usted tiene ciertos derechos. Puede solicitar que le muestren o le entreguen una copia an papel de su historial médico y otra información médica que tengamos de usted. Pregúntenos cómo hacerlo. Le entregaremos una copia o un resumen de su información

Puede solicitarnos que no utilicemos ni compartamos determinada información médica para el tratamiento, pago o para nuestras operaciones

Si usted le ha otorgado a alguien la representación médica o si alguien es su tutor legal, aquella persona puede ejercer sus derechos y tomar decisiones sobre su información médica. Nos aseguraremos de que la persona tenga esta autoridad y pueda actuar en su nombre antes de tomar cualquier medida.

Para determinada información médica, puede decirnos sus decisiones sobre qué compartimos. Si tiene una preferencia clara de cómo compartimos su información en las situaciones descritas debajo, comuníquese con nosotros. Díganos qué quiere que hagamos, y seguiremos sus instrucciones.

No utilizaremos ni compartiremos su información de otra manera distinta a la aquí descrita, a menos que usted nos diga por escrito que podemos hacerlo. Si nos dice que podemos, puede cambiar de parecer en cualquier momento. Háganos saber por escrito si usted cambia de parecer.

Cumplir con la ley
Podemos compartir su información si las leyes federales o estatales lo requieren, incluyendo compartir la información con el Departamento de Salud y Servicios Humanos si éste quiere comprobar que cumplimos con la Ley de Privacidad Federal.

HOLISTIC CARE SOLUTIONS
DR. EMILIA CABRERA

Credit Card Authorization Form

Holistic Care Solutions
1108 Kane Concourse Suite 205
Bay Harbor Islands, FL 33154
P: 786-863-1114

CANCELATION POLICY

APPOINTMENTS: All appointments cancelled within the 24-hour period will incur a $75 cancelation fee. If you arrive 15 minutes late after your schedule appointment, you may not be accommodated for the entire duration of the service … of course we will be happy to complete the full service if we can!

Customer Name ____

Contact Phone Number (_______)____

Credit Card Number ____

Expiration Date _______/____

CVV/SECURITY Code ____

3- digit code on back for Visa and Master Card
4-digit code on front for American Express

Billing Address ____

City, State, Zip ____

Name as it appears on Card ____

Signature ____

Who is your primary care physician (family doctor)? Please include his or her mailing address and phone number.

____

____

TELL US ABOUT YOUR PROBLEM (HISTORY OF PRESENT ILLNESS)

What is you're the main reason or hour visit or one **most important** complaint?

____

____

MEDICAL HISTORY

(CHECK CONDITION THE PATIENT HAS NOW OR HAD IN THE PAST)

□ Latex allergy - YES
□ Latex allergy - NO

Eyes
□ Glaucoma
□ Cataract

ENT
□ Hearing loss
□ Cholesteatoma
□ Recurrent tonsillitis
□ Chronic sinusitis
□ Nasal polyps
□ Broken nose
□ Broken facial bones
□ Obstruct sleep apnea
□ Meniere's Disease
□ Otosclerosis

Cardiovascular
□ Hypertension
□ Coronary artery disease
□ Atrial fibrillation
□ Other arrhythmia
□ Congestive heart failure
□ Valvular heart disease
□ Varicose veins/phlebitis

Respiratory
□ Asthma
□ COPD
□ Lung cancer

Gastrointestinal
□ GERD
□ Peptic ulcer
□ GI bleed
□ Liver disease
□ Cirrhosis
□ Colon cancer
□ Crohn's disease
□ Diverticulitis
□ Renal failure
□ Kidney disease
□ Prostate enlarged
□ Prostate cancer
□ UTI-Recurrent
□ Infertility

Musculoskeletal
□ Osteoarthritis
□ Osteoporosis
□ Rheumatoid arthritis
□ Broken bones
□ Muscular dystrophy

Neurologic
□ CVA/Stroke
□ Brain tumor
□ Seizure disorder
□ Multiple sclerosis
□ Anxiety
□ Depression
□ Bipolar
□ Schizophrenia

Endocrine
□ Diabetes Type I
□ Diabetes Type II/oral
□ Hypothyroidism
□ Hyperthyroidism
□ Thyroid disorder

Skin
□ Skin disease

Hem/Lymphatic
□ Cancer
□ Anemia
□ Blood transfusion
□ Hyperlipidemia
□ hypercholesterolemia
□ Deep vein thrombosis
□ Hemochromatosis

Allergy/Immunologic
□ Allergic rhinitis
□ Fibromyalgia
□ Hepatitis B
□ Hepatitis C
□ Tuberculosis
□ MRSA
□ HIV/AIDS
□ VRE

____ ____History of STI's (sexually transmitted infections):
(HPV, genital warts, chlamydia, herpes, gonorrhea, syphilis, other________)
____ ____Have you ever been tested for HIV disease?
If Yes, what year? ___________________
If No, would you like to be tested? Yes No

Are you sexually active? Yes No

FAMILI HISTORY

Diseases & Conditions	*Mother*	*Father*	*Sister*	*Brother*	*Maternal Grandparent*	*Paternal Grandparent*
Alcoholism/Drub abuse						
Alzheimer's						
Asthma						
Autoimmune Disease						
Breast Cancer						
Cancer Breast						
Cancer Colon						
Cancer Lung						
Cancer Other type						
Cancer Ovarian						
Cancer Prostate						
Colon Cancer						
Colon Polyp						
Depression						
Diabetes						
Diabetes Type II						
Emphysema						
Genetic Disorder (explain)						
Glaucoma						
Heart Attack						
Heart Disease						
Hepatitis B						
Hepatitis C						
High Blood Pressure						
High Cholesterol						
Hip Fracture						
Hypothyroidism						
Kidney Disease						
Kidney Stones						
Macular Degeneration						
Osteoporosis						
Stroke						
Sudden Cardiac Death						
Other (list)						
Other (list)						

If your mother, father, brothers or sisters are deceased, please list their age at the time of death and the cause:

____

____

MEDICAL PROCEDURES OR SURGERIES

Surgical Procedure	***Yes***	***Year***	***Comments***
Abdominal surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back surgery (lumbar)			
Biopsy (location in comments)			
Breast Biopsy			Circle: Right Both
Breast surgery			Circle: Right Both
Cataract surgery			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
C-Section			
Echocardiogram (heart)			
EGD (Stomach Endoscopy)			
Gallbladder Removal			Circle: Laparoscopic
Heart Surgery			
Hip Surgery			Circle: Right Left Both
Hysterectomy (partial, ovaries left)			Circle: Laparoscopic Abdominal
Hysterectomy (total, including			Circle: Laparoscopic Abdominal
Knee Surgery			Circle: Right Left Both
LEEP (Cervix surgery)			
Neck (Spine) surgery			
Ovary Removal			Circle: Right Left Both
Pulmonary Function Test			
Sigmoidoscopy			
Sinus Surgery			
Stress Test (stress echo)			
Stress Test (thallium/perfusion)			
Stress Test (treadmill)			
Tonsillectomy			
Tubal ligation			
Vasectomy			
Other (list)			

SOCIAL HISTORY

Do you smoke: **YES NO** Packs per day: _______ How many years: _____________
Do you drink: **YES NO** Amount per day/week/month _______ How many years ______

Do you exercise regularly? **YES NO** If yes, what kind of exercise?______________________
____

DIET

What do you consider a good weight for yourself? ___________________________________

What is the most you have ever weighed (including when pregnant)? ____________________

Number of meals you usually eat per day: ____

Number of times per week you usually eat the following:
Beef ____________ Fish ___________ Desserts __________
Pork ____________ Chicken ________ Fried Foods ________

Number of servings (cups, glasses, or containers) per week you usually consume of:
Homogenized (whole) milk ________ Buttermilk _________________ Skim (nonfat) milk ____
2% (low-fat) milk _______________ 1% (low-fat) milk ___________ Coffee _______________
Tea (iced or not) _______ Regular or diet sodas __________ Glasses of water _____________

Do you usually use oil or margarine in place of high cholesterol shortening or butter?

Yes No

Do you usually abstain from extra sugar usage?
Yes No

Do you usually add salt at the table?
Yes No

Do you eat differently on weekends as compared to weekdays?
Yes No

ALLERGIES TO MEDICATIONS

Medication	Reaction

CURRENT MEDICATIONS

(please include over the counter medications and food supplements)

Drug Name	Dose	How Often?	Drug Name	Dose	How Often?

General

- ☐ Poor Appetite
- ☐ Poor Sleeping
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Tremors
- ☐ Cravings
- ☐ Localized Weakness
- ☐ Poor Balance
- ☐ Change in appetite
- ☐ Bleed or Bruise Easily
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Cold Hands
- ☐ Cold Feet
- ☐
- ☐ Peculiar Tastes or Smells
- ☐ Strong Thirst (cold or hot drinks)
- ☐ Sudden Energy Drop (What time of day?) ____________________

Skin and Hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Recent Moles
- ☐ Change in Hair or Skin Texture

Any Other hair or skin problems? ____

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Cataracts
- ☐ Blurry Vision
- ☐ Earaches
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Spots in Front of Eyes
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Recurrent Sore Throats
- ☐ Grinding Teeth
- ☐ Facial Pain
- ☐ Sores
- ☐ Teeth Problems
- ☐ Jaw Clicks
- ☐ Headaches (Where and When?) ____________________

Any other head or neck problems? ____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Swelling of the Hands
- ☐ Swelling of the Feet
- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Difficulty in Breathing

Any other heart or blood vessel problems? ____

Respiratory

- ☐ Cough
- ☐ Coughing Blood
- ☐ Chest Pain
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with a Deep Breath
- ☐ Difficulty in Breathing when Lying Down
- ☐ Production of Phlegm (What color?)

Any other lung problems? ____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black Stools
- ☐ Blood in Stools
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal Pain or Cramps
- ☐ Stool Consistency
- ☐ Chronic Laxative Use

Any other problems with your stomach or intestines? ____________________________________

Genito-Urinary

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urgency to Urinate
- ☐ Unable to Hold Urine
- ☐ Kidney Stones
- ☐ Decrease in Flow
- ☐ Impotence
- ☐ Sores on Genitals

Do you wake up to urinate? _______ How often? ________________________

Any particular color to your urine? _________________

Any other problems with your genital or urinary system? ________________________

Pregnancy and Gynecology

_____ Number of pregnancies _____ Number of Births _____ Premature Births

_____ Miscarriages _____ Abortions _____ Age at first Menses

_____ Period between menses _____ Duration First date of last menses _________

- ☐ Unusual Character (Heavy or Light)
- ☐ Painful Periods
- ☐ Clots
- ☐ Last PAP
- ☐ Vaginal Discharge
- ☐ Vaginal Sores
- ☐ Breast Lumps
- ☐ Changes in body / psyche prior to menstruation

Do you practice birth control? ______ What type and for how long? ______________

Musculoskeletal

- ☐ Neck Pain
- ☐ Muscle Pains
- ☐ Knee Pain
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Foot / Ankle Pains
- ☐ Hand / Wrist Pains
- ☐ Shoulder Pain
- ☐ Hip Pain

Any other joint or bone problems? ____

Neuropsychological

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Poor Memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad Temper
- ☐ Easily Susceptible to Stress

Have you ever been treated for emotional problems? ______

Have you ever considered or attempted suicide? ______

Any other neurological or psychological problems? ______________________________

Comments (please tell us of any other problems that you would like to discuss)

Neuropsychological

- ☐ Seizures ________
- ☐ Areas of numbness _______
- ☐ Concussion ________
- ☐ Bad temper ________
- ☐ Dizziness ________
- ☐ Poor memory _______
- ☐ Depression ________
- ☐ Easily susceptible to stress
- ☐ Loss of balance ________
- ☐ Lack of coordination ______
- ☐ Anxiety ________
- ☐ Treated for emotional problems________________________________
- ☐ Considered or attempted suicide ________________________________
- ☐ Any other neurological or psychological problems ________________________________

Classical indications and diagnostic inquiry—looking, listening, smelling:

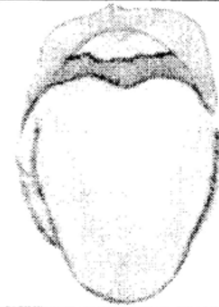
Preference	Most Liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Mood		

Body type	Yin/Yang Balance
Colors	Firm/Weak
Tones	Hot/Cold
Odors	Surface/Interior

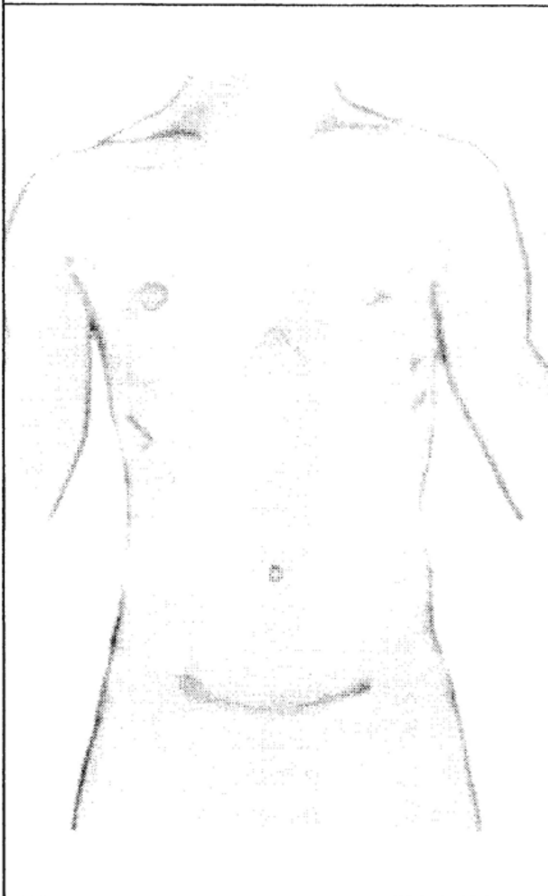
Tongue

Tongue Qualities

☐ Dry	☐ Moist	☐ Wet
☐ Greasy	☐ Peeled	☐ Lolling
☐ Prickles	☐ Hard	☐ Loose
☐ Curled	☐ Rough	☐ Swollen
☐ Ulcerated	☐ Other ______________	

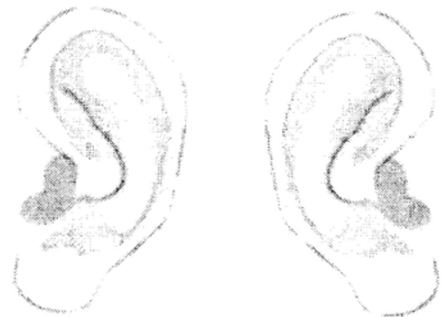


Abdominal palpation



Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
U	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
−	colder
+	hotter
Physical	
Ø	sores
*	rashes
« »	spasms

Ear



Sensitive Ear Points

Copyright © 2002 Redwing Book Company, Inc

Pulse palpation

Left Pulse				Right Pulse			Description
Rear	Middle	Front		Rear	Middle	Front	Rate / Qualities
+	+	+	Superficial	+	+	+	
+	+	+	Middle	+	+	+	
+	+	+	Deep	+	+	+	

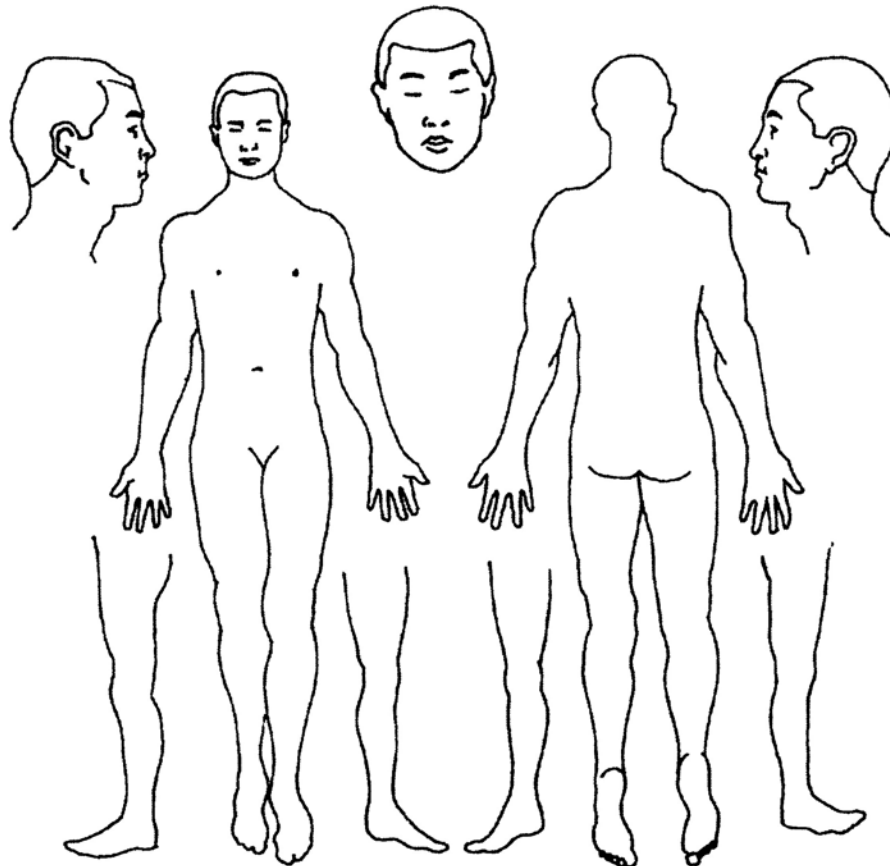
Comments: ______________________________

Point palpation

	HT	SI	PC	TW	LU	LI	SP	ST	KI	BL	LR	GB
	CV-14	CV-4	CV-15(17)	CV-5	LU-1	ST-25	LR-13	CV-12	GB-25	CV-3	LR-14	GB-24
Left												
Right												
	BL-15	BL-27	BL-14	BL-22	BL-13	BL-25	BL-20	BL-21	BL-23	BL-28	BL-18	BL-19
Left												
Right												

Areas painful or distressed on palpation

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
U	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
–	colder
+	hotter
Physical	
Ø	sores
*	rashes
« »	spasms



Assessment

Objective Symptoms ______________________________

General Diagnosis ______________________________

Subjective Symptoms ______________________________

Treatment Strategy ______________________________

Copyright © 2002 Redwing Book Company, Inc