

Harvey M. Pearlman

Patient Forms

BA, LMT, CNMT, BTSF

Dear patient:

The instructions may appear ambiguous or difficult to read so I will add to the instructions here. Check the symptoms you experienced that come and go (chronic) and the ones which are present now (acute). In some cases you will be checking both columns. Be sure to include all of your complaints. The second part of page 4 is for women only. Men sometimes don't like to complain but make this an exception and go for it. On page 3, if something doesn't apply just circle 0. You can circle whole groups at once to speed it up for you. Please sign the application at the bottom of page 2. Also, please sign the two agreement pages and date them. Thank you.

I am looking forward to receiving your application back and reviewing it in anticipation of your first visit.

If you have any questions, please do not hesitate to call.

Once we begin your sessions any time sensitive communications are best handled via vm pager (727-259-8232), please.

Sincerely,

Harvey Pearlman
MM 10710 MA 3019

1135 S. Pasadena Ave., Suite 327G
South Pasadena, FL 33707
727-259-8232

Respiratory
 Acute Chronic
 _____ Chronic cough
 _____ Asthma
 _____ Emphysema
 _____ Recurrent head colds
 _____ Recurrent sinus infections
 _____ Recurrent bronchitis
 _____ Smoker

Genito-Urinary
 Acute Chronic
 _____ Too frequent urination
 _____ Discolored or foul-smelling urine
 _____ Blood in urine
 _____ Recurrent kidney or bladder infections
 _____ Kidney stones
 _____ Bed wetting
 _____ Inability to control bladder

Eyes/Ears
 Acute Chronic
 _____ Recurrent ear infections
 _____ Eye infection
 _____ Slowly losing vision
 _____ Floaters in eyes
 _____ Glaucoma
 _____ Macular degeneration
 _____ Cataracts
 _____ Diabetic retinopathy

Miscellaneous
 Acute Chronic
 _____ Difficulty sleeping
 _____ Restless
 _____ Edema
 _____ Unusual swelling in arms or legs

For Men Only
 Acute Chronic
 _____ Prostate trouble
 _____ Urination problems
 _____ Reproductive problems

Endocrine (Glandular)
 Acute Chronic
 _____ Cold hands and feet
 _____ Low blood pressure
 _____ Weight problems (over or under)
 _____ Thyroid problems
 _____ Diabetes
 _____ Irritable if meals are missed
 _____ Anxiety/nervousness/irritability
 _____ Dizzy upon standing too quickly
 _____ Weak and shaky
 _____ Hyperactive behavior
 _____ Depression
 _____ Very susceptible to infections
 _____ Frequent headaches
 _____ Digestive complaints

For Women Only
 Acute Chronic
 _____ Recurrent urinary tract infections
 _____ Yeast infections
 _____ Vaginal discharge
 _____ Menstrual irregularity
 _____ Cramping
 _____ Mood swings/depression
 _____ Pre-menstrual syndrome
 _____ Infertility
 _____ Frequent miscarriages
 _____ Hot flashes
 _____ Currently taking hormone medication
 _____ Currently taking birth control pills
 _____ Lumps in breast
 _____ Uterine cysts/ovarian cysts
 _____ Bladder leaks too easily
 _____ Endometriosis

List any other symptoms or unusual conditions that you feel are important:

1. _____
2. _____
3. _____

Patient's Signature _____

FOR DOCTORS USE ONLY

Axillary Temperature Test _____ Saliva pH _____ Urinary pH _____

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Pupillary Light Reflex _____

Diagnostic Summary _____

Date____/____/_____

When an appointment is arranged, that day and time are specifically designated for your treatment benefit and to accommodate your needs. To best maintain my focus and effectiveness to provide quality treatment to you, it is extremely important that you **call me at 727-438-9911, 48 HOURS AHEAD OF YOUR APPOINTMENT TO RESCHEDULE; THIS WILL AVOID FULL TREATMENT CHARGE* FOR YOUR MISSED APPOINTMENT.** *Serious medical emergencies excepted, of course.

As a Professional Massage Therapist, I am committed to providing optimal treatment for, and with, my patients. One important factor critical to good health and well-being is a clear understanding and agreement regarding appointments and scheduling. Thank you very much for your consideration and cooperation.

Yours for Stress and Pain Reduction

Harvey M. Pearlman, B.A., LMT

(SIGNATURE)

Patient _____
(PRINT)

(SIGNATURE)

Name _____

Health History

(Please list any injuries, pain, health problems, medications, disabilities, etc.)

I understand that the BodyTalk System is a healing modality used to improve the communication between the body and the mind.

I understand that I may experience my bodymind detoxifying for the next 48 hours and that the symptoms may be intense especially if I have a chronic health problem or am under a lot of emotional stress.

I understand and acknowledge that my participation in experiencing a BodyTalk Session is purely voluntary and that at all times I will be free to choose NOT to participate in any part or all of the BodyTalk Session.

I understand that everything that is discussed between me and the therapist will remain confidential.

I acknowledge my responsibility for exercising my own judgment and initiative in choosing to receive a BodyTalk session.

By this consent I knowingly and voluntarily assume responsibility for my healing process.

I hereby authorize _____ to provide me with a BodyTalk session.

Signed _____ Date ____/____/_____

Name _____ Date ____/____/____

Instructions: Please circle the number which best describes the frequency or severity of your complaints.
Leave the question blank if it does not apply to you.

0 = No Symptoms 1 = Mild Symptoms 2 = Moderate Symptoms 3 = Severe Symptoms

PART 1: STRUCTURAL

SECTION A:

- 1. Experience muscle cramps 0 1 2 3
- 2. Frequent muscle spasms 0 1 2 3
- 3. Low back pain 0 1 2 3
- 4. Leg muscles cramp at night 0 1 2 3
- 5. Muscles are tight 0 1 2 3
- 6. Muscular discomfort or pain 0 1 2 3
- 7. Muscle stiffness all over 0 1 2 3
- 8. Muscle stiffness after a good night sleep . 0 1 2 3

SECTION B:

- 1. Mild early morning stiffness 0 1 2 3
- 2. Loss or restriction of joint mobility 0 1 2 3
- 3. Pain that is worse after using a joint ... 0 1 2 3
- 4. Stiffness after periods of rest 0 1 2 3
- 5. Creaking/cracking of joints 0 1 2 3
- 6. Tenderness and swelling in certain areas .. 0 1 2 3
- 7. Diagnosed with osteoarthritis NO YES
- 8. Chronic fatigue and weakness 0 1 2 3
- 9. Low grade fever 0 1 2 3
- 10. Joint stiffness and joint pain 0 1 2 3
- 11. Painful, swollen joints 0 1 2 3
- 12. Severe joint pain with inflammation 0 1 2 3
- 13. Diagnosed with rheumatoid arthritis NO YES
- 14. Severe pain in first joint of big toe NO YES
- 15. Constipation/indigestion 0 1 2 3
- 16. Headaches 0 1 2 3
- 17. Heart or kidney problems 0 1 2 3
- 18. Diagnosed with gout? NO YES

PART 2: NEUROLOGICAL

SECTION A:

- 1. Experience tremors in hands and/or feet .. 0 1 2 3
- 2. Often nervous or "on edge" 0 1 2 3
- 3. Slurred speech 0 1 2 3
- 4. Easily lose your balance 0 1 2 3
- 5. Tire easily 0 1 2 3
- 6. Easily irritated 0 1 2 3
- 7. Frequent dizziness/light-headedness 0 1 2 3
- 8. Lack of coordination 0 1 2 3
- 9. Memory problems 0 1 2 3
- 10. Depression 0 1 2 3
- 11. "Spaciness" 0 1 2 3

SECTION C:

- 1. Have had spontaneous bone fractures0 1 2 3
- 2. Painful bones0 1 2 3
- 3. Eat red meat often0 1 2 3
- 4. Are you postmenopausal?0 1 2 3
- 5. Take anti-inflammatory medication0 1 2 3
- 6. Smoker0 1 2 3
- 7. Drink alcohol excessively0 1 2 3
- 8. Taken synthetic thyroid medication for long period of time.....0 1 2 3
- 9. Have calcium deposits in joints0 1 2 3
- 10. Drink large amounts of soda pop / coffee ...0 1 2 3
- 11. Family history of osteoporosis NO YES
- 12. Experienced early menopause (<45 yrs) NO YES
- 13. Diagnosed with osteoporosis/osteomalacia NO YES
- 14. Have a current bone fracture..... NO YES

SECTION D:

- 1. Loss of range of joint motion0 1 2 3
- 2. Persistent back pain0 1 2 3
- 3. Localized joint pain or tenderness0 1 2 3
- 4. Swollen joints0 1 2 3
- 5. Prone to injury0 1 2 3
- 6. Double-jointed (over-flexible joints)0 1 2 3
- 7. Do you have tendonitis?..... NO YES
- 8. Do you have bursitis?..... NO YES
- 9. Do you have a slipped disc? NO YES
- 10. Do you have a herniated disc? NO YES
- 11. Are you recovering from a current injury? ... NO YES

- 12. Ringing in your ears 0 1 2 3
- 13. Extremities numb easily 0 1 2 3
- 14. Head and/or limbs feel heavy 0 1 2 3
- 15. Blurred or double vision 0 1 2 3
- 16. Convulsions 0 1 2 3
- 17. Loss of muscle tone or muscle strength 0 1 2 3
- 18. Diagnosed with shingles 0 1 2 3
- 19. Lose temper easily, emotionally unsettled .. 0 1 2 3
- 20. Hand tremors 0 1 2 3
- 21. Hyperactive behavior 0 1 2 3

Name _____ Date ____/____/____

Instructions: Please circle the number which best describes the frequency or severity of your complaints.
Leave the question blank if it does not apply to you.

0 = No Symptoms 1 = Mild Symptoms 2 = Moderate Symptoms 3 = Severe Symptoms

PART 1: GLANDULAR

SECTION A:

- 1. Get dizzy when you stand up quickly 0 1 2 3
- 2. Lose your vision when you stand quickly ... 0 1 2 3
- 3. Weak and shaky often 0 1 2 3
- 4. Sensitive to bright light, sunlight, etc. . 0 1 2 3
- 5. Have allergies (hayfever, asthma, etc.) ... 0 1 2 3
- 6. "Lump in throat" that hurts when upset ... 0 1 2 3
- 7. Sensitive to environmental pollutants 0 1 2 3
- 8. Dry, flaky skin 0 1 2 3
- 9. Easily irritated 0 1 2 3
- 10. Crave salt 0 1 2 3
- 11. Heavy stress causes complete exhaustion ... 0 1 2 3
- 12. Easily startled or frightened 0 1 2 3
- 13. Loud noises cause your heart to pound 0 1 2 3
- 14. Form "goosebumps" easily 0 1 2 3
- 15. Are you a perfectionist? 0 1 2 3
- 16. Dark circles under your eyes 0 1 2 3
- 17. Difficult time breathing 0 1 2 3

SECTION B:

- 1. Experience chronic fatigue 0 1 2 3
- 2. Gain weight easily 0 1 2 3
- 3. Sensitive to environmental pollutants 0 1 2 3
- 4. Easily depressed 0 1 2 3
- 5. Slow heart rate 0 1 2 3
- 6. Swollen eyes or face 0 1 2 3
- 7. Chronic constipation 0 1 2 3
- 8. Dry, flaky skin 0 1 2 3
- 9. Easily irritated 0 1 2 3
- 10. Slowed or slurred speech 0 1 2 3
- 11. Excess hair loss 0 1 2 3
- 12. Hair and/or nails are brittle and dry 0 1 2 3
- 13. Recurrent infections 0 1 2 3
- 14. Allergic reactions 0 1 2 3
- 15. Headaches 0 1 2 3
- 16. Heavy menstrual flow 0 1 2 3
- 17. Suffer form PMS 0 1 2 3
- 18. Painful periods 0 1 2 3
- 19. Low sex drive 0 1 2 3
- 20. Difficulty concentrating or remembering ... 0 1 2 3
- 21. Cry easily 0 1 2 3
- 22. Difficulty sleeping 0 1 2 3
- 23. Cold hands and feet 0 1 2 3
- 24. Axillary temperature below 97.5 F 0 1 2 3

SECTION C:

- 1. Rapid heartbeat (>90 beats/minute) 0 1 2 3
- 2. Bulging, swollen eyes 0 1 2 3
- 3. Sweat excessively with moist skin and palms 0 1 2 3
- 4. Increased appetite 0 1 2 3
- 5. Chest pains 0 1 2 3
- 6. Gastrointestinal disturbances 0 1 2 3
- 7. Difficult to relax 0 1 2 3
- 8. Insomnia 0 1 2 3
- 9. Menstrual problems 0 1 2 3

- 12. Enlarged thyroid (goiter)0 1 2 3
- 13. Experience tremors (trembling)0 1 2 3
- 14. Increased body temperature0 1 2 3
- 15. Fatigue0 1 2 3
- 16. Anxious and nervous0 1 2 3
- 17. Low tolerance to heat0 1 2 3
- 18. Lose weight easily0 1 2 3

SECTION D:

- 1. Feel better after eating0 1 2 3
- 2. Fatigued if meal is missed0 1 2 3
- 3. Hungry for sweets0 1 2 3
- 4. Symptoms occur in afternoon or several hours after eating0 1 2 3
- 5. Memory problems or poor concentration0 1 2 3
- 6. Wake up at night feeling hungry0 1 2 3
- 7. Digestive complaints0 1 2 3
- 8. Headaches relieved by sweets or alcohol0 1 2 3
- 9. Anxiety/nervousness0 1 2 3
- 10. Rapid heart rate0 1 2 3
- 11. Extreme hunger0 1 2 3
- 12. Weak/shaky/jittery0 1 2 3
- 13. Irritable if meal is missed0 1 2 3
- 14. Increased body temperature0 1 2 3
- 15. Double vision0 1 2 3

SECTION E:

- 1. Irritable0 1 2 3
- 2. Frequent urination0 1 2 3
- 3. Weakness or fatigue0 1 2 3
- 4. Unusual hunger0 1 2 3
- 5. Excessive thirst0 1 2 3
- 6. Nausea/vomiting0 1 2 3
- 7. Cuts that will not heal0 1 2 3
- 8. Vision problems0 1 2 3
- 9. History of diabetes in your family0 1 2 3
- 10. Overweight0 1 2 3
- 11. Tingling/numbness in feet0 1 2 3
- 12. Tingling/numbness in feet0 1 2 3

SECTION F:

- 1. Bloating of abdomen0 1 2 3
- 2. Redness and bloating of face0 1 2 3
- 3. Fatigue0 1 2 3
- 4. Overweight at the hips/waist (pear-shaped) .0 1 2 3
- 5. Menstrual irregularities0 1 2 3
- 6. Lack of menstruation in younger girls0 1 2 3
- 7. Water retention/edema0 1 2 3
- 8. Thyroid problems0 1 2 3
- 9. Slowed growth in children0 1 2 3
- 10. Cold hands and feet0 1 2 3
- 11. Cold all over0 1 2 3
- 12. Infertility0 1 2 3
- 13. Sex drive reduced or lacking0 1 2 3
- 14. Chronic headaches at level of eyes0 1 2 3
- 15. Mental and/or emotional stress0 1 2 3

- 10. Rash or swelling in front of lower leg 0 1 2 3
- 11. Diarrhea 0 1 2 3

SECTION G:

- 1. Very susceptible to infections 0 1 2 3
- 2. Chronic swollen glands in neck/groin/armpit 0 1 2 3
- 3. Frequent flu-like symptoms 0 1 2 3
- 4. Irregular heartbeat 0 1 2 3
- 5. Soreness in neck 0 1 2 3
- 6. Infections last longer than 7 days 0 1 2 3
- 7. Over the age of 50..... NO YES

PART 2: FOR MALES ONLY

SECTION A:

- 1. Increased urinary frequency 0 1 2 3
- 2. Need to urinate during the night 0 1 2 3
- 3. Reduced urinary flow with increased strain 0 1 2 3
- 4. Difficulty in urinating or stopping urine . 0 1 2 3
- 5. Pain or burning during urination 0 1 2 3
- 6. Discharge from penis after bowel movements 0 1 2 3
- 7. Blood or pus in urine 0 1 2 3
- 8. Back pain or leg pain 0 1 2 3
- 9. Fever/chills 0 1 2 3
- 10. Impotence (difficult to maintain erection) 0 1 2 3
- 11. Lost or diminished sex drive 0 1 2 3
- 12. Prostrate trouble..... NO YES

SECTION B:

- 1. Inability to achieve or maintain erection . 0 1 2 3
- 2. Premature ejaculation 0 1 2 3

PART 3: FEMALES ONLY

SECTION A: Do you have any of these symptoms during menstruation?

- 1. Lower abdominal pain 0 1 2 3
- 2. Back ache 0 1 2 3
- 3. Pinching/pain sensation in inner thighs .. 0 1 2 3
- 4. Intense cramps right before period 0 1 2 3
- 5. Bloating of your abdomen 0 1 2 3
- 6. Sugar craving 0 1 2 3
- 7. Light or heavy blood flow 0 1 2 3
- 8. Anxious about getting your period 0 1 2 3
- 9. Stay in bed the first few days of period .. 0 1 2 3
- 10. Pain during period is getting worse 0 1 2 3

SECTION B:

- 1. Lack of menstruation 0 1 2 3
- 2. Irregular periods 0 1 2 3
- 3. Vaginal itching or abnormal discharge 0 1 2 3
- 4. Low sex drive 0 1 2 3
- 5. Regularly do strenuous exercise 0 1 2 3
- 6. 15 years or older and haven't gotten period NO YES
- 7. Diagnosed or believe you have anorexia NO YES
- 8. Unable to get pregnant..... NO YES
- 9. Are you 5-10 lbs under ideal weight? NO YES
- 10. Have you had any miscarriages? NO YES
- 11. Have you had any abortions? NO YES

SECTION C: Symptoms prior to menstruation?

- 1. Depressed 0 1 2 3
- 2. Altered sex drive 0 1 2 3
- 3. Breast pain 0 1 2 3
- 4. Back ache 0 1 2 3
- 5. Abdominal bloating 0 1 2 3
- 6. Swelling in hands and feet 0 1 2 3
- 7. Anxiety and/or suicidal feelings 0 1 2 3
- 8. Easily irritated and/or mood swings 0 1 2 3
- 9. Cramps 0 1 2 3

- 16. Abnormal thirst0 1 2 3
- 17. Excessive urination0 1 2 3

SECTION H:

- 1. Lack of coordination in the dark0 1 2 3
- 2. Symptoms worse in the evening0 1 2 3
- 3. Difficulty waking in the morning0 1 2 3
- 4. Irregular sleep habits0 1 2 3
- 5. Symptoms worse in fall and/or winter0 1 2 3

- 3. Inability to ejaculate0 1 2 3
- 4. Low or diminished sex drive0 1 2 3
- 5. Currently taking medication (anti-hypertensives, tranquilizers or Tagamet)0 1 2 3
- 6. Inability to impregnate a woman NO YES
- 7. Is your sperm count low?..... NO YES

SECTION C:

- 1. Unusual discharge from penis0 1 2 3
- 2. Itchy genitals0 1 2 3
- 3. Swelling or pain in genital area0 1 2 3
- 4. Recent changes in urination (frequency, etc.) 0 1 2 3
- 5. Burning in the genital area0 1 2 3
- 6. Bumps or blisters on the genitals0 1 2 3
- 7. Visible warts on genitals0 1 2 3
- 8. Diagnosed with sexually transmitted disease (herpes, gonorrhea, warts, etc.) NO YES

- 10. Weight gain each month0 1 2 3
- 11. Crying for no apparent reason0 1 2 3
- 12. Sugar craving0 1 2 3
- 13. Headaches0 1 2 3

SECTION D:

- 1. Small lumps in your breast0 1 2 3
- 2. Breast pain and tenderness0 1 2 3
- 3. Breast swelling/tender to touch0 1 2 3
- 4. Painful ovaries0 1 2 3
- 5. Lower abdominal pain0 1 2 3
- 6. History of breast cancer in your family NO YES
- 7. Never been pregnant..... NO YES
- 8. Recent pap smear test positive..... NO YES
- 9. Do you have ovarian cysts?..... NO YES
- 10. Do you have endometriosis..... NO YES
- 11. Mother used D.E.S. (hormones) while pregnant with you NO YES
- 12. Sudden onset of pain on one side of abdomen half way between monthly cycles NO YES

SECTION E:

- 1. Hot Flashes0 1 2 3
- 2. Weight gain0 1 2 3
- 3. Memory loss0 1 2 3
- 4. Irritability/mood swings0 1 2 3
- 5. Depression0 1 2 3
- 6. Vaginal dryness and pain0 1 2 3
- 7. Anxiety (sometimes followed by chills)0 1 2 3
- 8. Low sex drive/low arousal time0 1 2 3
- 9. Heart palpitations0 1 2 3
- 10. Water retention0 1 2 3
- 11. Night sweats and/or sweat throughout day0 1 2 3
- 12. Above symptoms and over age 45?..... NO YES
- 13. Have you had a hysterectomy?..... NO YES
- 14. Diagnosed with osteoporosis..... NO YES