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

Cross Pointe Plaza
3530 1st Ave. North
Suite 114
St. Petersburg, FL 33713
727-259-8232

Harvey M. Pearlman **Patient Forms – Personal History** BA, LMT, CNMT, BTSF

Name _____ SS# _____-____-_____ Date ____/____/____

Address _____ City _____ State ____ Zip _____

Phone (H) _____-_____-_____ (W) _____-_____-_____ Employer _____

Email Address(es)_____@_____.____, _____@_____.____

Birthdate ____/____/____ Age ____ Sex ____ Height _____ Weight ____ Marital Status _____

Main complaint(s) that brought you to this office _____

Other doctors seen for this condition _____

When this began _____ Due to accident: Yes ____ No ____

Medications / Vitamins Taking and Why

1. _____
2. _____
3. _____

Any injuries, operations, history and When

1. _____
2. _____
3. _____

Who referred you to our office? _____ Advertising _____ Other _____

Who is responsible for your bill besides yourself: ___ Insurance ___ Work Comp ___ Parents ___ Other

Name, address and phone of responsible party checked above _____

_____

Name of Insured _____ Supervisor _____

Instructions: Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested. Please check the symptoms you have experienced in either (or both) of the chronic (recurrent symptoms) or acute (symptoms you have now). IF symptoms are acute and have also occurred intermittently over a period of time, please check both boxes (chronic and acute).

Gastro-intestinal

Acute	Chronic	
_____	_____	Digestive complaints
_____	_____	Stomach pain
_____	_____	Ulcers
_____	_____	Frequent heartburn
_____	_____	Nausea
_____	_____	Frequent diarrhea
_____	_____	Irritable bowel
_____	_____	Hemorrhoids
_____	_____	Frequent vomiting
_____	_____	Colitis/diverticulitis
_____	_____	Black or bloody stool
_____	_____	Gallbladder trouble
_____	_____	Frequent burping/belching

Structural/Neurological

Acute	Chronic	
_____	_____	Headaches
_____	_____	Muscle cramps/muscle spasms
_____	_____	Neck pain
_____	_____	Dizziness
_____	_____	Back pain
_____	_____	Shoulder / elbow wrist pain (circle)
_____	_____	Numbness/Tingling
_____	_____	Tremors in hands or feet
_____	_____	Knee pain / Hip pain (circle)
_____	_____	Joint pain or loss of function
_____	_____	Osteoporosis/Osteomalacia
_____	_____	Current bone fracture or injury
_____	_____	Tendonitis/Bursitis

Immune Response

Acute	Chronic	
_____	_____	Frequently Sick
_____	_____	Frequent swollen glands/sore throat
_____	_____	Depression and/or anxiety
_____	_____	Achy joints/muscle pain
_____	_____	Headaches/migraines
_____	_____	Recurrent digestive complaints
_____	_____	Chronic fatigue
_____	_____	Food allergies
_____	_____	Eczema or hives
_____	_____	Allergies (mild / moderate / severe)

Cardiovascular

Acute	Chronic	
_____	_____	Irregular heartbeat
_____	_____	Heart murmur/palpitations
_____	_____	High or low blood pressure
_____	_____	Chest pain
_____	_____	Previous heart trouble
_____	_____	Poor circulation
_____	_____	Previous heart surgery
_____	_____	Varicose or spider veins
_____	_____	Hands and feet cold all the time

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_____

_____

Harvey M. Pearlman **Patient Treatment Scheduling Agreement** BA, LMT, CNMT, BTSF

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 727-259-8232, 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 ctitical to good health and well-being is a clear understanding and 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)

Harvey M. Pearlman **Patient Forms – Consent Form** BA, LMT, CNMT, BTSF

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 discusses 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____/____/_____

Harvey M. Pearlman **Patient Forms – Structural / Neurological Questionnaire** BA, LMT, CNMT, BTSF

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

SECTION C:

1. Have had spontaneous bone fractures 0 1 2 3
2. Painful bones 0 1 2 3
3. Eat red meat often 0 1 2 3
4. Are you postmenopausal? 0 1 2 3
5. Take anti-inflammatory medication 0 1 2 3
6. Smoker 0 1 2 3
7. Drink alcohol excessively 0 1 2 3
8. Taken synthetic thyroid medication for long period of time.....0 1 2 3
9. Have calcium deposits in joints 0 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 motion 0 1 2 3
2. Persistent back pain 0 1 2 3
3. Localized joint pain or tenderness 0 1 2 3
4. Swollen joints 0 1 2 3
5. Prone to injury 0 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

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
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

Harvey M. Pearlman **Patient Forms – Structural / Neurological Questionnaire** BA, LMT, CNMT, BTSF

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 temperature 0 1 2 3
15. Fatigue 0 1 2 3
16. Anxious and nervous 0 1 2 3
17. Low tolerance to heat 0 1 2 3
18. Lose weight easily 0 1 2 3

SECTION D:

1. Feel better after eating 0 1 2 3
2. Fatigued if meal is missed 0 1 2 3
3. Hungry for sweats 0 1 2 3
4. Symptoms occur in afternoon or several hours after eating 0 1 2 3
5. Memory problems or poor concentration 0 1 2 3
6. Wake up at night feeling hungry 0 1 2 3
7. Digestive complaints 0 1 2 3
8. Headaches relieved by sweets or alcohol 0 1 2 3
9. Anxiety/nervousness 0 1 2 3
10. Rapid heart rate 0 1 2 3
11. Extreme hunber 0 1 2 3
12. Weak/shaky/jittery 0 1 2 3
13. Irritable if meal is missed 0 1 2 3
14. Increased body temperature 0 1 2 3
15. Double vision 0 1 2 3

SECTION E:

1. Irritable 0 1 2 3
2. Frequent urination 0 1 2 3
3. Weakness or fatigue 0 1 2 3
4. Unusual hunger 0 1 2 3
5. Excessive thirst 0 1 2 3
6. Nausea/vomiting 0 1 2 3
7. Cuts that will not heal 0 1 2 3
8. Vision problems 0 1 2 3
9. History of diabetes in your family 0 1 2 3
10. Overweight 0 1 2 3
11. Tingling/numbness in feet 0 1 2 3
12. Tingling/numbness in feet 0 1 2 3

SECTION F:

1. Bloating of abdomen 0 1 2 3
2. Redness and bloating of face 0 1 2 3
3. Fatigue 0 1 2 3
4. Overweight at the hips/waist (pear-shaped) ..0 1 2 3
5. Menstrual irregularities 0 1 2 3
6. Lack of menstruation in younger girls 0 1 2 3
7. Water retention/edema 0 1 2 3
8. Thyroid problems 0 1 2 3
9. Slowed growth in children 0 1 2 3
10. Cold hands and feet 0 1 2 3
11. Cold all over 0 1 2 3
12. Infertility 0 1 2 3
13. Sex drive reduced or lacking 0 1 2 3
14. Chronic headaches at level of eyes 0 1 2 3
15. Mental and/or emotional stress 0 1 2 3

10. Rash or swelling in fron tof 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. Bach ache 0 1 2 3
3. Pinching/pain sensation sin 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 excercise 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 thirst 0 1 2 3
17. Excessive urination 0 1 2 3

SECTION H:
1. Lack of coordination in the dark 0 1 2 3
2. Symptoms worse in the evening 0 1 2 3
3. Difficulty waking in the morning 0 1 2 3
4. Irregular sleep habits 0 1 2 3
5. Symptoms wors in fall and/or winter 0 1 2 3

3. Inability to ejaculate 0 1 2 3
4. Low or diminished sex drive 0 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 penis 0 1 2 3
2. Itchy genitals 0 1 2 3
3. Swelling or pain in genital area 0 1 2 3
4. Recent changes in urination (frequency, etc.) 0 1 2 3
5. Burning in the genital area 0 1 2 3
6. Bumps or blisters on the genitals 0 1 2 3
7. Visible warts on genitals 0 1 2 3
8. Diagnosed with sexually transmitted disease (herpes, gonorrhea, warts, etc.) ..... NO YES

10. Weight gain each month 0 1 2 3
11. Crying for no apparent reason 0 1 2 3
12. Sugar craving 0 1 2 3
13. Headaches 0 1 2 3

SECTION D:
1. Small lumps in your breast 0 1 2 3
2. Breast pain and tenderness 0 1 2 3
3. Breast swelling/tender to touch 0 1 2 3
4. Painful ovaries 0 1 2 3
5. Lower abdominal pain 0 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 endrometriosis..... 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 Flashes 0 1 2 3
2. Weight gain 0 1 2 3
3. Memory loss 0 1 2 3
4. Irritability/mood swings 0 1 2 3
5. Depression 0 1 2 3
6. Vaginal dryness and pain 0 1 2 3
7. Anxiety (sometimes followed by chills) 0 1 2 3
8. Low sex drive/low arousal time 0 1 2 3
9. Heart palpitations 0 1 2 3
10. Water retention 0 1 2 3
11. Night sweats and/or sweat throughout day 0 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