

JJAPI, INC.
1575 Indian River Blvd Suite C-130
Vero Beach, FL 32960
772-770-6184

Please fill in the following information as completely as possible. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME _____ DATE _____

ADDRESS _____

CITY/STATE _____ ZIP _____

HOMEPHONE _____ CELL PHONE _____

EMAIL _____

DATE OF BIRTH _____ AGE _____ TIME OF BIRTH _____ AM/PM

PLACE OF BIRTH _____ MARITAL STATUS _____ CHILDREN _____

PLACE OF EMPLOYMENT _____

WORK PHONE _____ BEST # TO REACH YOU _____

How did you learn about our office? _____

Major Medical Complaint: _____

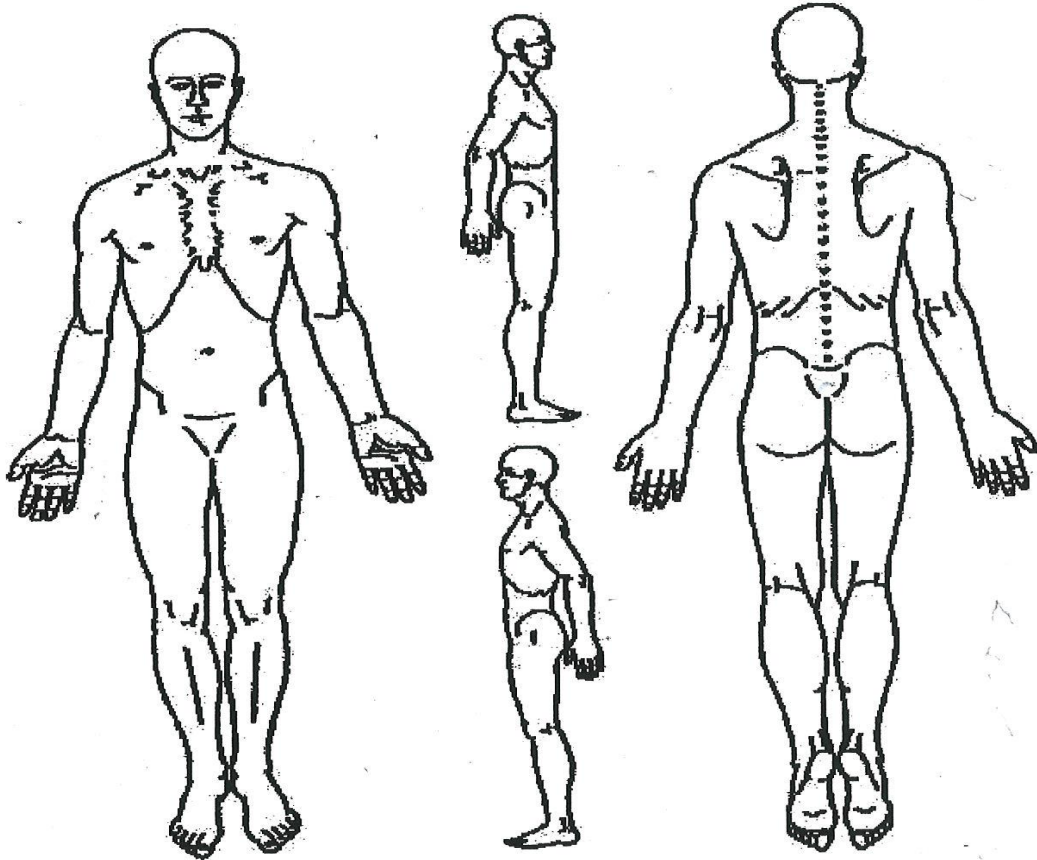
Medications: _____

Surgical History: _____

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

JJAPI, INC.

Are you requesting medical care to treat an injury you received as a result of an accident (auto accident/slip & fall/ work injury)?

YES _____ NO _____

If yes, please answer the questions below. If no, disregard remaining questions and sign below.

Did the accident occur while at work?

YES _____ NO _____

Have you filed a claim with an insurance company?

YES _____ NO _____

If yes, which insurance company and when: _____

Have you filed a worker's compensation claim?

YES _____ NO _____

Are you represented by an attorney?

YES _____ NO _____

If yes, please list name and telephone number of attorney: _____

X _____ DATE _____

Signature of Patient or Responsible Party

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name _____ Phone Number _____
Name _____ Phone Number _____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ NO _____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES _____ NO _____

PATIENT NAME _____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE

DATE

JJAPI, INC.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND ITEX.

Regarding Insurance Payment

In signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective as the original.

X _____ DATE _____

Signature of Patient or Responsible Party

JJAPI, INC.

CONSENT FOR ORIENTAL MEDICINE

Scope of Practice

The "scope of practice" for an acupuncturist in the state of Florida includes but is not limited to the following list of techniques:

- Use of acupuncture needles to stimulate acupuncture points and meridians
- Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians
- Acupressure
- Laserpuncture
- Acupoint injection therapy
- Gua Sha
- Cupping
- Dietary advice based on traditional Chinese medical theory

I recognize the potential risks/side effects and benefits of these procedures as described below:

Potential risks/side effects may include, but are not limited to the following:

- Pain following treatment in insertion area
- Temporary discoloration of the skin
- Aggravation of symptoms existing PRIOR to the treatment
- Minor bruising
- Broken needle
- Infection
- Needle sickness

NOTE: Patients with bleeding disorder, pacemakers, seizure disorders, or women who are currently pregnant, MUST notify the practitioner.

Potential benefits may include, but are not limited to the following:

- Drugless relief of presenting symptoms
- Improved general health
- Elimination of the presenting problem
- Reduction of pain and associated symptoms

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by JJAPI, INC. of Vero Beach, regarding cure or improvement of my condition. I hereby release JJAPI, INC. of Vero Beach from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time

PATIENT/GUARDIAN
SIGNATURE

DATE

Yours in Health,

Nemesia Sorcar, AP
Chisie Klinglesmith, AP
Acupuncture Physicians