Sun-Rise Acupuncture, Inc.
Janine M. Margewicz, AP
Fl. License # AP 2269
Winter Garden, Fl 34787
(407) 617-7378

Dear New Patient,

Welcome! Thank you so much for your interest in acupuncture and Oriental medicine. At Sun-Rise Acupuncture we do our best in every way possible to assure that you receive the best quality care. We want you to know that everyone on our staff is trained to:

- Make sure that our customer service always meets the highest standards.
- Make sure that any questions you have about your care are answered in a way that you can understand.
- Make sure that your phone calls are returned promptly.
- Make sure that your private health care information is kept secure and private.

Enclosed you will find several forms that we'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call us at (407) 617-7378 and any one of us will be happy to help you.

Again, welcome to Sun-Rise Acupuncture. You have taken an important step on the road to more vibrant health. We look forward to serving you.

Yours sincerely,

Janine M. Margewicz
Sun-Rise Acupuncture, Inc.

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (407) 617-7378.

Yours truly,

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Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Janine M. Margewicz, AP of Sun-Rise Acupuncture, Inc for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Sun-Rise Acupuncture, Inc.* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *Sun-Rise Acupuncture, Inc.* is not required to agree to the restrictions that I may request. However, if Sun-Rise Acupuncture, Inc. agrees to a restriction that I request, the restriction is binding upon *Sun-Rise Acupuncture, Inc.*

I have the right to revoke this consent, in writing, at any time except to the extent that *Sun-Rise Acupuncture, Inc.* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Sun-Rise Acupuncture, Inc's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Sun-Rise Acupuncture, Inc. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Sun-Rise Acupuncture, Inc. with respect to my identifiable health information.

Sun-Rise Acupuncture, Inc. reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

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Sun-Rise Acupuncture, Inc.

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/ or substances from the Oriental Materia Medica by the licensed Acupuncture Physician, Janine M. Margewicz, AP (FL), of Sun-Rise Acupuncture, Inc.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping: I understand that if I receive cupping as part of therapy, there is a likelihood of bruising and/or discoloration on the body-area on which cupping is preformed. There may also be a slight probability of mild discomfort from this procedure. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction of diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Sun-Rise Acupuncture, Inc. immediately.*

Acupressure/ Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Signature: _____ Date: _____
Signature of parent or guardian if patient is a minor (under 18 years of age)

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Phone: _____

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION
I requested and received in substantial detail further explanation of the procedure or treatment other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X_____
Patient's Signature and Date

X_____
Explained by me & signed in my presence / date

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Health History Questionnaire

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

I. General Patient Information

Date:

Last Name: First Name:

Address:

City, State, Zip Code:

Home Phone: Work Phone: Cell Phone:

E-Mail: Social Security Number:

Age: Date of Birth: Place of Birth:

Gender: Height: Weight: Marital Status

Occupation: Employer:

Guardian (if under 18):

Guardian Phone Number:

Major Complaint(s), in order of significance to you:

1.
2.
3.
4.

How do these conditions interfere with your daily activities?

1.
2.
3.
4.

Please list any medications that you are taking:

Please list any vitamins, herbs or supplements you are taking:

Please list any surgeries you have had and when:

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II. Patient Medical History

Recent tests- Please indicate test results and date below.

☐ Physical ☐ Blood ☐ Mammography ☐ Pap Smear ☐ Prostate

☐ Cholesterol ☐ HIV/STD ☐ Other:

Test Results and Date:

Check any you have had in the past.

☐ Diabetes	☐ Gonorrhea	☐ Hepatitis
☐ Allergies	☐ Mumps	☐ Multiple Sclerosis
☐ Glaucoma	☐ Bleeding Tendency	☐ Paralysis
☐ Rheumatic Fever	☐ Syphilis	☐ Cancer
☐ Heart Disease	☐ Measles	☐ Migraines
☐ CVA (Stroke)	☐ Chicken Pox	☐ High Blood Pressure
☐ Vein Condition	☐ Nervous Disorder	☐ Other Lung Illnesses
☐ Thyroid Disorder	☐ Meningitis	☐ Other Liver Illnesses
☐ Asthma	☐ HIV	☐ Other Heart Illnesses
☐ Pneumonia	☐ Polio	☐ Other Kidney Illnesses
☐ Tuberculosis	☐ Mononucleosis	☐ Other
☐ Emphysema	☐ Epilepsy	
☐ Jaundice	☐ High Fever	

Immunizations:

Any Adverse Reactions?

III. Patient Profile

Please clearly state any areas of pain and any scars. Indicate which of the areas are scars.

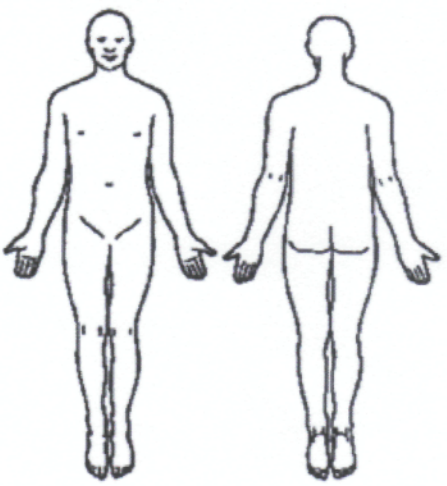
Is the pain...

☐ Sharp ☐ Dull

☐ Burning ☐ Moving

☐ Aching ☐ Fixed

☐ Cramping ☐ Other



Do the following lessen the pain?

☐ Pressure ☐ Exercise

☐ Cold ☐ Other

☐ Heat

Do the following worsen the pain?

☐ Pressure ☐ Exercise

☐ Cold ☐ Other

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Please check the following that currently pertain to you. If you have symptoms in the following categories. It can indicate that you may have a problem with that organ's function:

Overall Temperature- Kidney Function

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temperature (sensation)
- ☐ Cold body temperature (sensation)
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet, and chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Take water to bed

Overall Energy- Lung/Kidney Function

- ☐ Shortness of breath
- ☐ Difficulty keeping eyes open- daytime
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise

Overall Blood- Liver/Spleen/Heart Function

- ☐ Dizziness
- ☐ See floating black spots

Heart Function

- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on the tip of the tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Pacemaker
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Drink coffee-# cups per day: _____

Lung Function

- ☐ Nasal Discharge-Color: _____
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies- To What? _____
- ☐ Sneezing
- ☐ Headache: _____
- ☐ Overall Achy Feeling In The Body
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Sore Throat
- ☐ Difficulty Breathing
- ☐ Smoke Cigarettes-# Per Day: _____
- ☐ Sadness

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Spleen Function

- ☐ Low Appetite
- ☐ Abrupt Weight Gain
- ☐ Abrupt Weight Loss
- ☐ Abdominal Bloating
- ☐ Abdominal Gas
- ☐ Gurgling Noise In Stomach
- ☐ Fatigue After Eating
- ☐ Prolapsed Organs-Diagnosed

Which Organ?

- ☐ Easily Bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-Thinking
- ☐ Worry

Spleen, Stomach, Large Intestine Function

- ☐ Loose Stool
- ☐ Constipated
- ☐ Incomplete Evacuation
- ☐ Diarrhea
- ☐ Blood In Stools
- ☐ Mucous In Stools
- ☐ Undigested Food In Stools

Dampness In The Body

- ☐ General Sensation Of Heaviness In The Body
- ☐ Mental Heaviness
- ☐ Mental Sluggishness
- ☐ Mental Fogginess
- ☐ Swollen Hands
- ☐ Swollen Feet
- ☐ Swollen Joints
- ☐ Chest Congestion
- ☐ Nausea
- ☐ Snoring

Stomach Function

- ☐ Burning Sensation After Eating
- ☐ Large Appetite
- ☐ Bad Breath
- ☐ Mouth (Canker) Sores
- ☐ Bleeding, Swollen Or Painful Gums
- ☐ Heartburn
- ☐ Acid Regurgitation
- ☐ Ulcer- Diagnosed
- ☐ Belching
- ☐ Hiccoughs
- ☐ Stomach Pain
- ☐ Vomiting

Liver/Gall Bladder Function

- ☐ Alternation Diarrhea And Constipation
- ☐ Chest Pain
- ☐ Tight Sensation In The Chest
- ☐ Bitter Taste In The Mouth
- ☐ Anger Easily/ Frustration/ Irritability
- ☐ Frequently Unable to Adapt to Stress
- ☐ Depression
- ☐ Muscle Twitching
- ☐ Muscle Cramping
- ☐ Seizures/ Convulsions
- ☐ Drink Alcohol
- ☐ Lump In The Throat
- ☐ Neck Tension/ Limited Range of Motion
- ☐ Shoulder Tension/ Limited Range of Motion

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Liver/Gall Bladder Function (continued)

- ☐ Skin Rashes
- ☐ Headache At The Top Of The Head
- ☐ Tingling Sensation
- ☐ Numbness
- ☐ Muscle Spasms
- ☐ Recreational Drugs: Which?
- ☐ How Often Per Week?
- ☐ High-Pitched Ringing In The Ears
- ☐ Gall Stones
- ☐ Sexually Transmitted Disease(s)?

Eyes- Liver Function

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry Vision
- ☐ Decreased Night Vision
- ☐ Near-Sighted
- ☐ Far-Sighted

Kidney/Urinary Bladder Function

- ☐ Frequent Cavities
- ☐ Easily Broken Bones
- ☐ Sore Knees
- ☐ Weak Knees
- ☐ Cold Sensation In The Knees
- ☐ Low Back Pain
- ☐ Memory Problems
- ☐ Wake During Night Twice Or More To Urinate
- ☐ Low-Pitched Ringing In The Ears
- ☐ Kidney Stones
- ☐ Bladder Infections
- ☐ Lack Of Bladder Control
- ☐ Fear
- ☐ Easily Startled
- ☐ Excessive Hair Loss

Urination

- ☐ Normal Color
- ☐ Dark Yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong Odor
- ☐ Blood
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Painful
- ☐ Urgent
- ☐ Frequent

Libido

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For Women Only

Regular Menstrual Cycle?

Pregnant At This Time?

Number Of Children?

Number Of Pregnancies?

Age Of First Menstruation?

Age Of Menopause?

Average # Of Days Of Flow?

Average # Of Days Of Cycle?

Vaginal Discharge?

Bleeding Between Periods?

Do You Experience Any Of The Following Pre-Menstrual Syndromes?

- ☐ Nausea
- ☐ Vomiting
- ☐ Water Retention
- ☐ Breast Swelling
- ☐ Food Cravings
- ☐ Headaches
- ☐ Migraines
- ☐ Breast Tenderness
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Other Emotions?
- ☐ Dull Pain - Where?
- ☐ Sharp Pain - Where?

Please answer the following questions about your menstration. Select all that apply.

Your Menstrual Cycle Is Generaly:

Color: ☐ Normal ☐ Bright ☐ Red ☐ Pale ☐ Brown ☐ Rust ☐ Purple ☐ Other

Amount Of Flow?

Pain / Cramps?

Clots?

Vomiting?

Nausea?

Other Comments:

Patient's Signature: _____

Acupuncturist's Signature: _____