SAGE
Pain & Recovery Alternatives

First Name:	Last Name:	Gender
Address:		
City:	State:	Zip:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:		
Emergency contact:	Relationship:	Phone:
Referred by:		

Please describe the main reason for your visit today:

_____

_____

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

List all major childhood and adult illnesses:

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____

_____

PATIENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

- ☐ Cold hands/feet
- ☐ Fatigue
- ☐ Feverish in the afternoon or flushes
- ☐ Heat sensation in hands, feet, chest
- ☐ Night sweats
- ☐ Catch colds easily
- ☐ Sweats easily during daytime
- ☐ Dizziness
- ☐ See floating black spots

- ☐ Palpitations
- ☐ Sore on tongue
- ☐ Restlessness
- ☐ Anxiety
- ☐ Chest pain
- ☐ Insomnia

- ☐ Cough
- ☐ Sinus congestion
- ☐ Dry mouth, throat, nose, or skin
- ☐ Allergies seasonal or food
- ☐ Chills and fever
- ☐ Stiff neck/shoulders
- ☐ Sore throat
- ☐ Difficult breathing

- ☐ Low appetite
- ☐ Loose stools
- ☐ Constipation
- ☐ Abdominal bloating or gas after eating
- ☐ Feeling tired after eating
- ☐ Prolapsed organs (previously diagnosed)
- ☐ Bruises easily
- ☐ General feeling of heaviness in body
- ☐ Mental heaviness or fogginess
- ☐ Swollen hands/feet
- ☐ Burning sensation after eating
- ☐ Bad breath
- ☐ Large appetite
- ☐ Mouth, canker or cold sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn/belching
- ☐ Stomach pain
- ☐ Vomiting/nausea

- ☐ Diarrhea alternating with constipation
- ☐ Tight/suffocating feeling in chest
- ☐ Bitter taste in mouth
- ☐ Blood shoot eyes/dry eyes
- ☐ Anger easily
- ☐ Skin rashes
- ☐ Headache
- ☐ Numbness of hands and feet
- ☐ Muscle spasms, twitching, cramping
- ☐ Seizures/convulsions

- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination
- ☐ Get up more than once a night to urinate
- ☐ Lack of bladder control
- ☐ Memory problems
- ☐ Hair loss
- ☐ Ringing in ears

Urine is:

- ☐ Normal color ☐ Clear
- ☐ Dark yellow ☐ Reddish
- ☐ Cloudy ☐ Scanty
- ☐ Bad odor
- ☐ Burning ☐ Painful
- ☐ Difficult ☐ Urgent

Libido (sex drive) is:

☐ Normal ☐ Low ☐ High

Women only:

1. Are you pregnant now?
☐ Yes ☐ No

2. Number of children:_____

3. Number of pregnancies:_____

4. Age of first period:_____

5. Age of menopause if applicable:_____

6. Is your menses cycle regular?
☐ Yes ☐ No

a. Average number of days in flow:____

b. The flow is:
☐ Normal ☐ Heavy ☐ Light

c. The color is:
☐ red ☐ dark ☐ purple
☐ light brown ☐ brown

d. Do you have the following menstruation related symptoms?

☐ Blood clots
☐ Cramps
☐ Nausea
☐ Breast distension
☐ PMS
☐ Bleeding between periods
☐ Heavy vaginal discharge between periods

e. Birth control:_____

Men Only:

☐ Discharge

☐ Pain or swelling of testicles

☐ Ejaculatory problems

☐ Impotence/erectile dysfunction

Signature _____

Date_____

SAGE
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AUTHORIZATION FOR ACUPUNCTURE TREATMENT

I, _____, request and consent to the performance of acupuncture therapies and other Chinese medical procedures by Sage Health Group LLC doing business as Sage Pain and Recovery Alternatives.

I understand that acupuncture in not intended to replace conventional medical treatment and that any diagnosis of my condition(s) must be performed by a licensed physician.

I further understand that acupuncture treats health conditions by stimulating points found at specific locations on the surface of the body. Small stainless steel, disposable needles are inserted into the skin to stimulate or disperse energy called Qi (pronounced "chee") and to produce physiological effects. Pain and ill-health result when the flow of Qi through the body is disrupted or blocked by things like disease, pathogens, stress, poor diet or trauma. Acupuncture helps to restore even flow of Qi and other nutrients throughout the body, thereby restoring health and balance to the body, while relieving pain and other symptoms. As part of my treatment, I understand that the acupuncturist may perform adjunct treatments such as cupping, tui-na, moxibustion, gua-sha, electrical stimulation, or herbal treatments.

I realize there are risks and potential side effects that can be caused by the treatments including bruising, headaches, fatigue, or minor discomfort at the insertion site. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of my treatment which he or she feels, based upon the facts known, is in my best interest. I will immediately notify Sage Pain and Recovery Alternatives of any negative side effects or problems that I experience.

By signing below, I acknowledge that I have been told the potential risks associated with acupuncture and I have had the opportunity to ask questions. I intend for this consent and release to cover the entire course of my treatment for my present condition and any future condition(s) for which I seek treatment.

With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been made to me by Sage Pain and Recovery Alternatives or any individual therapist, regarding the improvement of my ailment or condition(s).

I understand that any fees for treatment are payable at the time service is rendered.

I agree to give **24 hours notice** if I need to cancel an appointment. I understand that without advance notice, Sage Pain and Recovery Alternatives reserves the right to charge me a fee for the missed appointment. Insurance companies will not reimburse me for missed appointments. Exceptional circumstances will be considered.

_____ _____

Signature of Patient Date

_____ _____

Signature of Person Authorized to Consent Date

SAGE
Pain & Recovery Alternatives
7116-C Six Forks Rd., Raleigh, N.C. 27615

Authorization for disclosure of health information and direct contact

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, we understand that we have, and always will, respect the privacy of your health information.

Disclosures of protected health information

Listed below are several reasons for having to use or disclose your PHI (personal health information)

- We may have to disclose your information to another healthcare provider or hospital should we refer you to them for a diagnosis, assessment, or treatment of your health condition.
- We may have to disclose PHI and /or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or operational purposes.

Your right to limit uses of disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI, we will respectfully request that you submit these restrictions in writing. With your right to restriction, you also have the right to revoke your authorization or consent to us at any time. Again, this change of authorization is requested in writing before your file status will be changed.

ESTABLISHED PATIENTS: We have a more complete notice that provides a detailed description of how your information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520) and is available upon your request. Please sign below to confirm this for has been gone over with you.

NEW PATIENTS: In your packet of new patient information you will find our Notification of Patient Privacy Policy. Please sign below to confirm that you have received it.

Authorization and permission

In general, the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their PHI. The individual is also provided the right to request confidential communications, such as reminders of appointment times, follow up of health care, insurance coverage's/benefits issues or any other information that only the patient will personally be able to answer.

Below, please authorize any person(s) that we may discuss your treatment/finances with or that we may release your medical records to. Those listed below will also have your permission to schedule or change appointments on your behalf as needed.

Person 1:_____

Person 2:_____

Is there a way you would prefer for us **NOT** to contact you? yes/no
If you circled yes, please let us know how **NOT** to contact you: _____

Patient Signature_____Date_____

Print Name_____DOB_____Chart #_____