SAGE
Pain & Recovery Alternatives

COMMUNITY ACUPUNCTURE PATIENT

First Name_____

Last Name_____

Gender _____

Address_____

City/Zip_____

Cell Phone_____

Home Phone_____

Date of Birth_____

Email_____

Emergency Contact Name & Phone_____

Referred by:_____

SAGE
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PATIENT NAME:_____

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 shot 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

Chief complaint today:_____

Pain level today (between 1 – 10):_____

Current Medications:_____

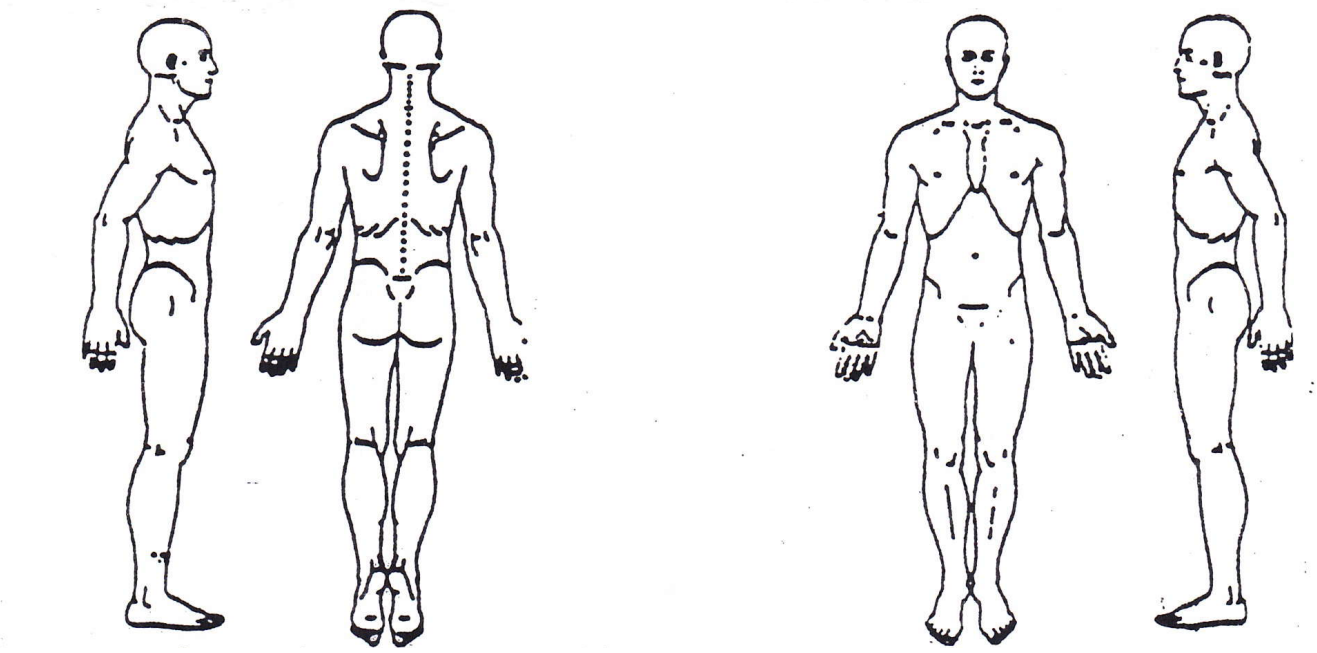
_____

_____

Please indicate if you have any of the following:

- ☐ Cardiac pacemaker
- ☐ Seizure disorder
- ☐ Bleeding disorder/blood thinners
- ☐ Fainting disorder
- ☐ HBP
- ☐ You are/may be pregnant
- ☐ HIV/AID positive
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Other: _____

On the figures below, please mark or shade in any areas of muscle or joint pain or stiffness.



SIGNATURE_____ DATE_____

FOR OFFICE STAFF ONLY BELOW

TREATMENT:_____

_____

_____

_____

_____

_____

_____

_____

_____

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 #_____