Sage Wellness Group

820 Fleming Street, Suite A
Hendersonville, NC 28791
PH: 828-696-8900, Fax: 828-595-2721

Welcome to Sage Wellness Group. We are honored to have you join our practice. Our focus is on education and establishing long term relationships to endorse long-term wellness for each individual and their families.

As well as our conventional testing services, we also offer alternative testing. Testing that is often not offered in conventional practices. We use multiple labs to offer as many options as possible, and testing for a large variety of conditions and symptoms.

We are a no balance office. We DO NOT ACCEPT insurance for office visits. Oftentimes labs are covered by insurance (not Medicare) but office visits are not. We will, however, give you a super-bill that you can use to submit your office visits to insurance for reimbursement directly to you (not Medicare).

Aside from our natural primary healthcare, we have photobiomodulation, ZYTO scans, massage therapy, colon hydrotherapy, custom meal service, custom dietary plans, organic facials with Micro-needling & PRP and chiropractic services.

Your first visit with Dr. Andersson is the start of your wellness journey. Dr. Andersson will be your healthcare detective to help you discover why and how your health may have gone awry. With this in mind, it can be quite time consuming to collect all the information necessary to make such a determination.

Therefore your first visit will be at least 2 hours, however, we set aside 2 ½ hours for each new patient. The 2nd visit is when Dr. Andersson will explain your test results and help you determine the best plan of care to achieve your optimum wellness. This typically lasts 30 – 60 minutes.

By showing up (and being on time) for your initial visit, we can continue to ensure prompt service and keep our fees affordable. **Please have your paperwork filled out prior to your first visit. If you are unable to print the paperwork, please let us know before your appointment.** We will either send you the packet in the mail or allow for you to come to your appointment 30 minutes early to fill it out.

We do not double-book patients. This means your appointment time is your appointment time. We pride ourselves on running on schedule. On occasion we may run behind due to an emergency, however, we respect and value your time; we ask that you offer us the same courtesy.

We understand that circumstances happen that may make it necessary for you to reschedule, however we request at least 48 hours notice for all cancellations. If you cancel your initial visit twice you will not be eligible to make another appointment.

We do not advertise our services, therefore, we kindly ask that you share with us who referred you so that we can properly thank them as a referral is the kindest form of compliment.

All of us here at Sage Wellness are focused on helping you achieve your best possible experience and optimum wellness. Feel free to reach out to us with any questions or concerns and be assured that your health and wellness is our number one priority.

Thank you,

Meet our Doctor:

Dr. Andersson has been practicing functional medicine for 22 years. She has raised 4 children and now has 5 grandchildren, 2 dogs and a cat. Along with her family, her practice is her passion and primary commitment. Besides office visits, she has multiple avenues of communication available for her patients including phone, email and text messages. She prides herself on being available to her patients so that they feel supported throughout their healing process.

She teaches ongoing classes and provides support to help with diet and lifestyle changes.

She specializes in autoimmune disorders such as: Fibromyalgia, Chronic Fatigue Syndrome, Psoriasis, Irritable Bowel Syndrome, Crohn's disease, as well as hormonal imbalances (such as PCOS and infertility), overall GI complaints, ASD (spectrum disorders), methylation, genetic analysis, pre and post natal nutrition, diabetes, metabolic syndrome, NAFLD, genetic counseling and overall natural primary care.

Primarily her mission is education. No one can heal someone else. A doctor does not heal, a doctor teaches, guides, advises and the individuals heal themselves with life-style, diet, and emotional-physical-spiritual balance.

Dr. Andersson's primary focus is on the patient. She does testing and exhaustive research when necessary, to discover the root cause of the disorder so that the patient can be treated properly. She spends a lot of time with her patients to develop relationships that are most conducive to healing, positive life changes and optimum wellness.

Thank you for scheduling an appointment with Sage Wellness Group. In an effort to get to know you better, we have included some forms that we need you to fill out prior to your first visit. The more honest and complete you can be with your answers, the better we will be able to help you.

On the day of your initial visit, please do not wear any nail polish or perfumes/colognes. Please bring all your medications & supplements, and if possible be fasting (nothing by mouth except water/black coffee/plain tea) after midnight.

Also, if possible, do not take any supplements for three days prior to your first appointment. Supplements can change your results. Our goal is to determine exactly what your body needs and may have deficiencies in, supplements will temporarily change levels. We need a base line to see exactly where you are. However, continue any medication prescribed by your physician.

Drink a full gallon of water the day before you come so you are hydrated for lab testing. The best way to hydrate is to combine a gallon of spring water with 1 sliced lemon, 1 sliced English cucumber and ½ tsp Himalayan salt. Sip on that all day prior to your first visit.

If you have time prior to your first visit, please keep a diary for 7 days, keeping track of what you ate, drank (including water), bowel movements (frequency, color and consistency), energy level, and sleep (amount and quality).

We understand that unforeseen things happen. We ask that you notify as soon as you can if you are unable to make your appointment. If you cancel less than 24 hours prior to your appointment, a $200 fee will be assessed. We will need a credit card number to hold your appointment. We will NOT charge you unless you are simply a no-show. We do not double book, we do not expect people to wait, and we set aside 2+ hours for new patient visits. Therefore if you do not show up, 2 hours is lost that could be used by someone else. We will always be respectful of your time; we ask that you do the same for us.

For any questions regarding your appointment or these forms, please call us at (828) 696-8900. Or email us at support@drmarieandersson.com. We look forward to meeting with you.

We would like to take this opportunity to acquaint you with our payment procedures. It is our goal to satisfy all of our patients and make financial aspects of your healthcare as convenient and simple as possible.

Our office does not file or bill insurance of any type because we do not have the equipment and systems necessary to file insurance. We are not affiliated with any insurance companies, therefore, we can dramatically reduce fees and pass the savings to you.

We offer these reduced fees while providing excellent service and top quality health care. This fee schedule will be beneficial for those in our community who do not have health insurance, have a high-deductible plan, or simply would like access to affordable wellness care. We do not sign contracts with insurance companies or HMO's. At Sage Wellness you are our #1 priority - not your insurance company.

The cost for the initial visit is $350.00 which is due the day of service. Plan to be in the office 2 – 2 1/2 hours. The visit includes a thorough review of your history and an exam with Dr. Andersson. If you want one, you will receive a "super-bill" via email, which is complete with ICD-10 codes and CPT codes that you may submit to your insurance company and therefore receive the reimbursement directly.

Be sure to bring a check or card to pay for some initial labs, which will be payable to the lab as we do not make money on labs.

If you have any questions regarding cost, procedures, follow up visits etc, please do not hesitate to ask questions. The goal of this office is to keep you informed, educate, and be sure that there are no surprises. We also expect our patients to take responsibility for their healthcare, please read and sign the "Responsibility Agreement."

In the event that you request your records be sent to another healthcare provider, written consent or a signed Healthcare Information Release Authorization form must be on file with our office for each request. By signing below, you agree to pay any charges incurred for each request.

Signed: _____ Date: _____

Privacy and confidentiality of personal health information is important to us. We have HIPAA policies in place to ensure your personal health information is available only to authorized persons who need access to this information to provide health care. No patient information leaves our office either electronically, by fax, or paper record without specific authorization by you. A copy of our privacy policy is posted at the front desk and you will receive a copy when you arrive.

Is it OK for us to leave a message on your voicemail? _____

I have received my copy of the HIPAA patient privacy information: _____

For Medicare Patients Only:

The services we provide are currently not reimbursable under Medicare or Medicaid. At this time, you may not submit our invoices for reimbursement. However, referrals to specialists, hospitals, and for procedures such as x-rays or MRI would still be covered by Medicare.

I read and understood the payment procedures and privacy policy of Sage Wellness Group and will agree to pay my bill in full at the end of my visit.

Signed: _____ Date: _____

****

Whom may we thank for referring you to our office?_____

Please do NOT wear nail polish or perfume when you come in for any exams.

Patient Signature:_____ Date:_____

Fee Schedule

We ACCEPT check, cash, credit, debit, and HSA cards.

Dr. Andersson:

Service	**Cost**
Initial Consultation/Exam (2-2.5 hours)	$350.00
Second Visit (includes lab work review, ZYTO Scan, lifestyle plan)	Varies on how long the meeting lasts
Initial Chiropractic only Exam (45 min)	$175.00
Spinal Adjustment	$55.00
Video Conference	$125/half hour, $250/hour
Photobiomodulation	$60.00 (10 sessions for $500)
Photobiomodulation plus Spinal Adjustment	$90.00 per session
Genetic Report	$75.00
Office Visits	$250.00/hour
In-Office Venipuncture Collection	$45.00
ZYTO Scan	$55.00

*Dr. Andersson offers her service to children under the age of 10 at ½ price.

Recommended Labs

Test Name	Price	Test Name	Price
Exclusive Tests			
HDL Map	$115	Cholesterol Balance	$34
HDL Map (Particles Only)	$88	Prediabetes Assessment	$37
Statin Induced Myopathy Genotype Test	$71	Heart Fatty Acid Balance	$13
Lifestyle Panel	$161		
Lipids			
ApoA-I	$15	ApoB	$15
Total Cholesterol	$4	LDL-C	$8
HDL-C	$7	Lipoprotein(a)	$11
Small Dense LDL	$12	Triglycerides	$5
LDL Particle Number	$27		
Comprehensive Metabolic Panel			
Glucose	$3	CO2	$4
Calcium	$4	Chloride	$4
Sodium	$4	Potassium	$4
BUN	$3	Creatinine	$4
Albumin	$4	Alkaline Phosphatase	$4
ALT	$5	AST	$4
Bilirubin (total/direct)	$4/$	Total Protein	$3
Kidney, Iron, Muscle			
Uric Acid	$4	Cystatin C	$13
Magnesium	$6	Phosphorus	$4
Iron	$6	UIBC	$8
Ferritin	$12	Creatine Kinase	$6
NT-proBNP	$29	B12	$13
CoQ10	$17	Folate	$13
Homocysteine	$15	Vitamin D	$26
Troponin T	$19	GGT	$6
Aldosterone	$35		
Inflammation Tests			

Hs-CRP	$11	LpPLA2 Activity	$32
Myeloperoxidase	$36	Fibrinogen	$10
Metabolic			
Adiponectin	$12	Glucose	$3
GSP	$13	Hemoglobin A1c	$8
Insulin	$10	HOMA-IR	$13
C-Peptide	$18		
Genetic			
Apolipoprotein E Genotype	$96	Factor V Leiden	$53
Factor II Genotype	$46	SLCO1B1	$45
CYP2C19	$204	MTHFR	$46
Complete Blood Count			
Complete Blood Count	$6	CBC with differential	$7
Thyroid			
TSH	$15	TSH, reflex to TT3 and FT4	$35
Total T3	$12	Total T4	$6
Free T3	$15	Free T4	$8
TPO	$13		
Hormones			
Male Hormone Panel	$88	Female Hormone Panel	$115
Additional Testing			
Food Allergy/ Sensitivity			$150-$729
Mycotoxin Test			$299
Organic Acid Test			$309
Comprehensive GI Test			$254-$379

PLEASE COMPLETE IN FULL PRIOR TO YOUR FIRST VISIT.

Today's Date:_____

Patient's Legal Name _____

Nickname _____Male ____ Female ____ Birthdate _____

Age _____ Email Address _____

Married ____ Single ____ Divorced ____ Widowed ____ (How long?_____)

Home Phone _____

Mobile Phone _____

Work Phone _____

Patient's Street Address _____City_____

State_____ Zip _____ Is this your mailing address? ___

If not please add:_____

If Patient is a minor, Parent/Guardian's Name and Phone Number

_____

Name, Relationship, and Phone number of Emergency Contact:

_____

Primary Care Physician: _____

Primary Care Physician Phone: _____

Primary Care Physician Address:_____

_____

Reason for visit? _____

If you have insurance to pay for your labs, please give a copy of your insurance card to the front desk. **Medicare CANNOT be used to pay for labs**.
Payment is due at time of service.

Health History

What are your goals for this visit? _____

_____

Prioritize your most important health concerns today?

Concern	Onset	Frequency	Severity
Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

With whom do you live? (Including pets) _____

Have you had any recent traumatic events?_____

What are the most important things to you? _____

What are the major stressors in your life? _____

What is your occupation? (Current)_____ (Past)_____

What do you do to relax/relieve stress? _____

What hobbies or interests do you have?_____

Spiritual beliefs/religion? _____

What are your sources of Comfort, Nurturing, and Connection? _____

If you could change one thing in your life, what would it be? _____

What physical activities do you participate in, and how often? _____

_____

_____

Nutrition/Digestion

How many meals do you generally eat per day? _____ Do you skip meals?_____

Do you snack in between meals?_____

How many servings of fruit per day and what kind? (Svg: 1 small fruit, ½ Cup canned/chopped fruit, ½

Cup dried fruit) _____

How many servings of vegetables per day and what kind? (Svg: ½ Cup raw/cooked, 1 Cup leafy veg.) _____

Are you currently on a special diet? (Vegetarian, macrobiotic, vegan, raw, other)

Food allergies, sensitivities or foods that you avoid?_____

How much dairy do you consume each day and what kind? (milk, cheese,

yogurt)_____

What amount and kind of carbohydrates do you eat? (grains, flour, bread, pasta, starchy vegetables,

sugars/sweeteners) _____

What are your sources of protein (soy, chicken, fish, beef, pork, beans, eggs)
_____

What type of oil, butter, or spreads do you add to your food?_____

What and how much do you drink on a typical day? (water, tea, coffee, caffeinated drinks, bottled

drinks, soda, etc.)_____

How would you describe your relationship with food? _____

How often and where do you eat out? _____

Do you eat organic food? _____

Who prepares the meals at home? _____

If you were to indulge or treat yourself to a food, what would it be? _____

Do you use an air and/or water purifier?_____(type_____) well water?____

Do you feel frequent (circle): bloating reflux constipation loose stools or pain after eating?

How frequently do you have a bowel movement? _____

Do you have difficulty digesting (circle): soy, wheat, dairy, fat, other_____

Amount per Day:

Cigarettes _____Cigars/Pipe/Chewing _____ Alcohol _____

THC/CBC _____ Vape (type) _____Other Substances _____

PERSONAL MEDICAL HISTORY

Please indicate, with a **P** or a **C**, if the following conditions apply to you **currently**, or have in the **past**, if a choice is given, please circle the appropriate one.

_____ Abuse, personal history of physical or sexual abuse ____
_____ Lung Disease (COPD, Emphysema, etc.)
_____ Addiction (Type_____)
_____ Anemia (Sickle Cell or Other)
_____ Arthritis/ Joint Disease
_____ Asthma
_____ Blood Clots/ Phlebitis
_____ Cancer (Type _____)
_____ Chemical sensitivity
_____ Chronic Pain
_____ Depression
_____ Diabetes
_____ Digestive (Ulcerative Colitis, Crohns, etc.)
_____ Easy Bleeding
_____ Fatigue
_____ Frequent Sinusitis
_____ Gastroesophageal Reflux (GERD)
_____ Gall Bladder Trouble
_____ Eating Disorder
_____ Hay Fever, Allergy, Eczema
_____ Hearing Loss
_____ Heart Arrhythmia (Type_____)
_____ Heart Attack, Heart Disease, Heart Failure
_____ Heart Murmur
_____ Headaches (Migraines, tension, cluster, complex, etc.)
_____ High Blood Pressure
_____ High Cholesterol
_____ History of Infertility
_____ Irritable Bowel Syndrome
_____ Kidney Infection/ Stones
_____ Liver Disease, Hepatitis, etc…
_____ Mental Trouble/Nervous Breakdown, psychosis
_____ Peptic Ulcer
_____ Pneumonia

_____ Prostate problems
_____ Radiation Treatments
_____ Chemotherapy (Type_____)
_____ Autoimmune Disorder (Type_____)
_____ Seizures, Epilepsy
_____ Serious Injury or Accident (Type _____)
_____ Sexually Transmitted Disease (Type_____)
_____ Skin Disease (Type_____)
_____ Stroke, TIA
_____ Suicide Attempt
_____ Thyroid Disease (goiter, nodule, High/Low Thyroid)
_____ Tuberculosis (TB)
_____ Urinary Difficulties (Incontinence, Infections, frequency)
_____ Vision Problems
_____ Ear Problems
_____ Blood in Stool
_____ Weight Problem (over /under weight)
_____ Sleep problems

Are you aware of any genetic variances? (Such as MTHFR, COMT, MAO etc)
_____

Have you had genetic testing?_____ 23andme?_____

_____ History of antibiotic use, if yes, how many times in your lifetime? If you are not sure, please give us an estimate: _____

Were you born via cesarean section? _____ Forceps/Vacuum?_____

_____ Traveled out of the country in the past year, where? _____

Please check any that apply to you **currently**:

__ Heartburn
__ Bloating
__ Constipation
__ Diarrhea
__ Alternating constipation/diarrhea

__ Loss of taste for meat
__ Crave sugar
__ Crave salt
__ Belly rash
__ Coated tongue
__ Skip meals
__ Get tired after eating
__ Afternoon slump
__ Get "shaky" when hungry
__ Pain in right upper back
__ Pain in abdomen, where? _____
__ Feels like air is trapped in stomach, especially after eating
__ Have trouble digesting cruciferous vegetables (cabbage, broccoli)
__ Eyes or nose watery
__ Eyelids swollen or puffy
__ Sunlight bothers eyes
__ Heart speeds up after eating
__ Increased pulse at rest
__ Ears or eyes itch
__ Belching or passing gas
__ Hands/feet cold
__ Burning feet
__ Muscle-leg-toe cramps at night
__ Excessive hair falling out
__ Frequent skin rashes
__ Coated tongue
__ Eyelids and face twitches
__ Increased frequency of urination
__ Night urination, how often? ___
__ Failing memory
__ Headaches
__ Abnormal thirst
__ Low blood pressure
__ High blood pressure
__ Hot flashes
__ Night sweats
__ Hair growth on body or face (female)
__ Chronic fatigue
__ Nails weak, ridged
__ Arthritic tendencies

__ Perspire easily
__ Difficulty breathing upon exertion
__ Allergies to food _____
__ Intolerance to heat
__ Highly emotional
__ Inward trembling
__ Irritable and restless
__ Restless legs at night
__ Weight gain around hips or abdomen
__ Sneezing attacks
__ Burning or itching anus
__ Mental sluggishness
__ Reduced initiative
__ Never seem to get well
__ Live in an old home
__ Been exposed to mold
__ Been exposed to other chemicals or heavy metals
__ Live or lived in a golf course community
__ Pain? Where_____

Any other symptoms?_____
_____
_____
_____

Family History

Who in your immediate family has any of the following?

Place appropriate letter in blank and circle type: (F=Father, M=Mother, S=Sister, B=Brother, Son=son, D=daughter)

(Example: __F__ High Blood Pressure)

_____ Alcoholism or Substance Abuse
_____ Anxiety
_____ Anemia (Sickle Cell or Other)(Other Type_____)
_____ Asthma
_____ Arthritis (Type_____)
_____ Blood clots
_____ Cancer (Type _____, date_____)

_____ Chronic Pain
_____ Depression
_____ Diabetes
_____ Digestive (Ulcerative Colitis, Crohns, etc.)
_____ Disability (From_____)
_____ Easy Bleeding
_____ Glaucoma
_____ High Blood Pressure
_____ Hay Fever, Allergy, Eczema
_____ Headaches (Migraine, tension, cluster, aneurysm)
_____ Heart Attack, Heart Disease, Heart Failure
_____ Heart Failure
_____ Heart arrhythmia
_____ High Cholesterol
_____ Irritable Bowel Syndrome
_____ Kidney Disease
_____ Liver Disease (Hepatitis, etc.)
_____ Lung Disease (Asthma, COPD, emphysema)
_____ Mental Trouble/ psychosis/ nervous breakdown
_____ Seizure, Epilepsy
_____ Stroke
_____ Suicide or attempted suicide
_____ Thyroid Disease (Goiter, high or low thyroid)
_____ Tuberculosis (TB)
_____ Ulcers
_____ Other

Please list any operations/ surgical procedures/ blood transfusions/ major injuries (with dates):
_____

Please list all physical accidents, such as car accidents, falls off ladders etc:_____

_____

Immunizations/vaccinations:
_____

Are you allergic to or have you had a “bad reaction” to any medication or other substance?

_____ Yes _____ No

Please list medication or substance and the reaction (what happened when you took it?):

Medication/Substance Reaction: _____

Energy and Sleep

How is your energy level?_____

Describe your sleep pattern (bed time, hours slept/night, usual wake up time:
_____

Do you need supplements or medication to sleep? _____ yes _____ no

Do you have sleep apnea or do you snore? _____ yes _____ no

Do you worry about sleeping? _____ yes _____ no

Do you need caffeine or other substances to stay alert? _____ yes _____no

Women Only

Reproductive History:

Age at 1st menstrual period _____ First day of last menstrual period_____
Usual Flow: Heavy _____ Moderate _____ Light_____
Length of period in days (days of flow)_____
Number of days in between periods _____
Do you have (please circle): Painful Periods, Missed Periods, Spotting Between Periods, Unusual Vaginal Bleeding?
Any unusual discharge, discomfort, infection, or recurring vaginal infections, and if so, what kind? _____
Please circle the method of contraception you are currently using
Birth Control Pills Type _____ Total Years of Use _____
IUD Type _____
What kind of menstrual protection do you use? Tampons pads Diva Cup
Other: Norplant Condom Foam/Suppository, Tubal Ligation, Hysterectomy, Vasectomy,

Herbal, Rhythm Method, Abstinence, Nuvaring, Unlisted:
_____

If you have gone through menopause, have you had any post menopausal bleeding? _____
Was menopause difficult? If yes, why? _____
Date of last pap: _____ History of abnormal pap smears? ____
Number of: Pregnancies____ Live Births___ Abortions___ Miscarriages____
Have you experienced complications during pregnancy/delivery/other problems?
_____
Have you ever had an abnormal breast exam or mammogram? ___ yes ____ no
When was your last breast exam, mammogram, thermogram or breast ultrasound?
_____

Men Only

Do you have or have had: Prostate Problems _____ Testicular Cancer _____ Vasectomy _____ Erectile Dysfunction _____ Urethral Discharge _____
Do you have incomplete, frequent, difficult or painful urination? ____ yes ____ no
Have you ever had an abnormal prostate exam or PSA? _____ yes _____ no

PRESCRIPTION MEDICATIONS - Please list on the table below ALL prescription medication you take or use.

Name of Medication and Strength
_____
_____
_____
_____

Do you, or have you in the past, taken any medication that is of the benzodiazepine type? (Valium, Xanax, Ativan, Ambien, alprazolam etc..)? If so, which one(s) and for how long?
_____

*People with a long term history of benzodiazepine use need consent from one of **our** doctors to receive care at Sage Wellness. Please notify the office in advance if this applies to you.*

NONPRESCRIPTION MEDICATIONS AND SUPPLEMENTS CURRENTLY OR RECENTLY TAKEN
(Vitamins, Minerals, Herbs, Herbal products, Remedies, and Other health products)

_____

_____

_____

Is there anything else that you think we should know?_____

MOLD QUIZ

1. Do you feel like you are running on a low battery?
    a. More often than I like
    b. I can rally but it takes more energy and more time to recharge
    c. No, I'm the energizer Bunny
2. Have you noticed that you seem to get sick more often than other people?
    a. Yes
    b. Maybe so
    c. No, I'm healthy as a horse
3. Are you gassy?
    a. Yes, shh!
    b. Sometimes
    c. Seldom
4. Are your sinuses inflamed or do you have a sinus-ey voice?
    a. Yes, my sinuses are often a problem
    b. Yes, but it comes and goes
    c. Not really
5. How often do you struggle to get your brain to focus, or to get your thoughts organized?
    a. It seems like a lot lately
    b. Occasionally
    c. Nope, I'm sharp as a tack
6. Do you have allergies and/or hay fever?
    a. Yes, definitely
    b. Only sometimes or in my bad season
    c. This isn't really a problem
7. Do you get bloated after eating sweets, or drinking Kombucha or other fermented beverages?
    a. Boy do I
    b. Sometimes, it depends
    c. No, I don't drink these beverages
8. Do you have digestive problems?
    a. Yes
    b. Sometimes
    c. Not really
9. How often do you feel like you can't get enough air, even if you take a deep breath?
    a. I rarely feel like I get enough air
    b. Sometimes I have a problem with this
    c. I never feel this way

10. Do you hear ringing in your ears in a relatively quiet room or when you are trying to fall asleep?
    a. All time, it's maddening
    b. Sometimes
    c. Not usually
11. Are you bothered by strong odors like perfumes, cleaning products or candles?
    a. Yes. I stay away from pretty much anything with a strong scent
    b. These occasionally bother me.
    c. Not usually
12. Even though no one would know it on the outside, do you feel uneasy on the inside?
    a. Almost all the time
    b. Sometimes, but I handle it
    c. Rarely
13. Do you find yourself yawning and/or sighing often?
    a. I do this a lot
    b. Now that I think of it, maybe so
    c. Not really
14. Do you ever feel a wheeze when you breathe, cough or laugh?
    a. Yes, most of the time
    b. Yes, but I'm in the cold air or laughing really hard
    c. No I don't
15. Have you ever had asthma?
    a. Yes
    b. No, but my doctor is considering it
    c. No, it’s not a problem
16. Have you noticed your vision changing lately?
    a. Yes
    b. A little bit
    c. No, I have not noticed this
17. Do you get headaches:
    a. Yes
    b. Sometimes
    c. Not really
18. In the past 6 months have you had yeast or fungal infections, such as jock itch, athletes’ foot, toenail fungus, or vaginal yeast infections?
    a. Yes, I have
    b. I’ve had one or two but it went away with treatment
    c. No, this isn't a problem
19. Would you say that you sleep well? In other words you can fall asleep easily and stay asleep until your alarm goes off?

a. Yes, I'm a champion sleeper
b. Not great but I get by
c. No way. What's sleep?

20. Do you have a runny nose and/or frequently sniff or sneeze?
    a. Yes it's a pain
    b. Yes but only at certain times
    c. Not me
21. Do you have reactions in musty places, spaces or buildings?
    a. Yes I have to leave immediately (ASAP)
    b. Yes but it's tolerable
    c. No, I have no problem in musty places.
22. Do you have an overactive or irritable bladder?
    a. Yes
    b. Occasionally
    c. Not a problem
23. Do you have dizziness or vertigo?
    a. Pretty frequently
    b. Sometimes, or worse, when I move too fast
    c. This isn't an issue for me
24. Has any building you've ever worked in had water damage?
    a. Yes
    b. No
    c. I don’t know
25. Are you aware of leaks or water damage where you live now or where you lived previously?
    a. Yes
    b. A few times
    c. Not that I am aware of
26. Do you regularly use a sinus spray or medication?
    a. Yes I can't live without it
    b. I use it but not daily
    c. Nope
27. Do you crave sweets or carbohydrates?
    a. Ugh-yes
    b. Not crave, but I do like a little sweet
    c. No
28. If you get sick do you recover quickly?
    a. Usually
    b. Sometimes, it depends
    c. No it often lingers

29. Do you have a dry or persistent cough?
    a. Yes
    b. In certain circumstances
    c. Not a problem
30. Do you have post-nasal drip or swallow phlegm?
    a. Yes
    b. Sometimes
    c. Nope

I will email your results so you'll have them forever.

A. First Name:_____

B. E-mail address:_____

Sage Wellness Group

PERSONAL INFORMATION AND CONSENT TO TREAT

Date: ___/____/____ First Name: _____ Last Name: _____

****

CONSENT TO TREAT: I hereby authorize Dr. Marie Andersson and her assistants to perform examinations, venipuncture (blood collection), saliva & urine testing, other noninvasive diagnostic testing and any other treatment that is medically necessary for me throughout the course of my treatment plan.

Signature: _____ Date: _____

CONSENT TO TREAT A MINOR CHILD: I, _____, hereby give my permission for Dr. Marie Andersson and her associates to treat my minor child with examinations and any other noninvasive procedures that are medically necessary.

Parent/Guardian: _____ Signature: _____ Date: _____
(Please Print)

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: By signing on the line below, I am indicating that I have been given a copy of the Health Insurance Accountability and Portability Act to read (HIPAA). I was also informed by Dr. Marie Andersson that a copy of these privacy practices can be made available to me anytime.
I also understand that Dr. Marie Andersson does not treat any diseases, only nutritional and biochemical imbalances and deficiencies. She also does not give advice or recommendations about prescription drugs. If you have been diagnosed with a disease and/or are taking prescription medication, you must follow-up with your prescribing physician for any changes or questions regarding those medications or disease state.
Patient Signature: _____ Date: _____

****

May we leave a voice message on your: (Please initial one) Home Phone _____ Cell Phone____ Work Phone _____ or any of these phones ____?

To our valued patients: In order to keep the cost of your healthcare at a moderate price, Sage Wellness is a zero balance facility. This means we do not bill our patients or send monthly statements. Payment is due at the time of each visit.
Scheduling Appointments: We understand that sometimes circumstances prevent our patients from keeping their scheduled appointments. If you cannot keep your regularly scheduled appointment, please notify our office 24 hours in advance so that others in need can take your appointment slot and we don't have to charge you. Also, if you are running more than 15 minutes late for your scheduled appointment, please notify our office. Thank you.

Responsibility Agreement

Patient Name:_____ Date:_____

This office is based on the vision and belief that people benefit most by taking responsibility for their health. The worst thing one can do for their health is to turn it over to someone else. This has become a common occurrence with "modern health care." You must be an active participant in your health care in order to achieve the benefits that you are seeking. It is imperative that you understand why you are making the changes that the health care provider is suggesting. Don't just take something (drug or nutraceutical) because someone tells you to. Instead ask questions and seek an understanding regarding your particular health concern. With deeper understanding and clarity you will find that the day to day decisions will be easier and also will benefit you tremendously. Knowledge is power.

This is why it is our mission to educate. The true definition of doctor is *teacher*. If your doctor isn't teaching you, he/she is not doing his/her job. We not only encourage questions but expect them.

Dr. Andersson can be reached in various ways: email, phone, text and of course via office appointment. Take advantage of these options as they are in place to help you. However, we do ask that you respect her time and only text questions or concerns during reasonable hours and keep it short. Questions requiring a longer explanation should be kept to an office visit.

We will also make it clear what your program of care is. This includes: dietary recommendations, supplement protocol, follow up visit and any needed referral to another health care practitioner. You will receive a document that details your supplement recommendations as well as when you are due for a follow up and what that next visit will entail.

This requires homework on your part. You must take responsibility for your appointments and order enough supplements to ensure that you do not run out during your prescribed protocol. We will do our best to make this as easy for you as we can.

I acknowledge that I have read this agreement and agree to the terms in order to receive care in this office.

_____ _____

Signature Date