

VA Patient Health History and Consent

Patient Name: _____ Last 4 of SSN: _____
Referring Provider: _____ Date of Birth: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Phone: _____

HEALTH HISTORY

Yes **Check any that apply:**

- ☐ Cardiac pacemakers or other electronically-powered implant*
- ☐ Pregnant*
- ☐ Cardiac fibrillation
- ☐ Recently consumed drugs or alcohol
- ☐ Sensitivity to electrical current
- ☐ Severe mental disorder
- ☐ Organ transplant(s)
- ☐ Epilepsy
- ☐ Open wounds
- ☐ Phlebitis or thrombophlebitis

Yes **Check any that apply:**

- ☐ Cancerous lesions
- ☐ Recent surgery
- ☐ Menstruating
- ☐ Lack of sensation in skin
- ☐ History of fainting**
- ☐ History of strokes
- ☐ High or low blood sugar
- ☐ High or low blood pressure**
- ☐ Botox treatments
- ☐ Dehydrated, or have not consumed water in the past two hours. Offer water.

* Contraindications.

** Watch for light headedness or fainting, and/or consult a physician. If anything is checked, use caution.

Medications: _____

Other medical conditions or concerns: _____

REFERRAL METHOD

- ☐ Sign-in sheet
- ☐ HCP verbal referral
- ☐ HCP written note
- ☐ Business card
- ☐ Text/MMS
- ☐ Email
- ☐ Other _____

INTERNAL USE ONLY:

- ☐ No conflict of interest
- ☐ Bonafide patient
- ☐ ID verified
- ☐ Release results

WAIVER OF LIABILITY

I understand that Avazzia devices are FDA-cleared for pain relief; the Avazzia device imparts electrical frequencies into the body; Avazzia does not prescribe medical treatments or diagnose; Avazzia personnel are not licensed medical practitioners and are not qualified to act as such; and known risks for TENS include burns, usually from prolonged use with TENS pads. I have truthfully answered the above list of contraindications/cautions for this therapy. I have stated all my known medical limitations. I am in good health and have no physical limitations which would affect my safe use of the devices. I understand and agree that it is recommended that I see a physician for any physical ailment that I may have. I consent to treatment, and in consideration of the treatment offered to me, I agree to advise if I feel any discomfort or uneasiness. I agree that I will not institute any suit or claim against Avazzia, their representatives, their employees, or practitioners for any damage, loss, or injury to either person or property. I am at least 18 years of age and otherwise legally competent to sign this agreement. This release shall be effective and binding upon me and my assigns.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

VA Patient Trial Record

Performed with the Avazzia® Microcurrent Device

Patient Name: _____ Date: _____ Time: _____

Health history and consent form completed? ☐ Yes (see other side of this page).

_____ (Patient to initial.) Yes, my provider referred me for an on-site demonstration of an Avazzia device.

1. Please rate patient's reported pain level BEFORE Avazzia treatment. (Circle face or number on scale below.)



2. Please describe patient's symptoms and location of the pain BEFORE Avazzia treatment.

3. Clinical Educator: _____ Device used: ☐ RSI ☐ UL ☐ PS3

Treatment start time: _____ Treatment end time: _____ Total minutes: _____

Protocols/modes used: _____

4. Please rate patient's pain level AFTER Avazzia treatment. (Circle face or number on scale below.)



5. Please describe patient's symptoms and location of the pain AFTER Avazzia treatment.

☐ I want this device. ☐ I do not want this device.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____