Dunn Chiropractic Clinic
A Pain & Wellness Practice Since 1922

George Siegfried, D.C.
Chiropractic Physician
Since 1983
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Welcome to the Clinic!

Bilateral Nasal Specific Consultation Form

Filled out by:_____

Name: _____ **Date**: _____
Address: _____**City:**_____**State**: _____
Zip: _____**Cell#**: _____ **Work#**: _____
Birthdate: _____ **Age**: _____ **Occupation**: _____
Email Address (your email is confidential and will NOT be given out**):**
_____
Emergency Contact Name:_____ **Phone#**_____
Whom may we thank for referring you? _____

Have you seen a Chiropractor before? Yes ☐ **N** ☐ **Were you happy with your care?** _____

Circle any that apply to you: (Sinusitis/Migraines/Traumatic Brain Injury/Concussion/Skull Fractures/Cognitive Disorders/Vertigo/Hearing Loss/Post Traumatic Stress Disorder, other)

Have you ever broken your nose? Yes ☐ **No** ☐ **Sinus Surgery? Yes** ☐ **No** ☐
If yes, when/how and please explain
_____
_____

Have you ever had any blows to your head that you can remember? Falls, Sports, fights, concussion(s), Etc? Yes ☐ **No** ☐
If yes, please explain what happened:_____
_____

Are you taking any of the medicines listed below? If yes, circle any that apply to you
Flonase / Sudafed /Afrin / Zyrtec/ Claritin/ Other(s): _____

Please write any additional symptoms or information that may be important for Dr.Siegfried to know:
_____
_____
_____

Please Go to Page 1:

Bilateral Nasal Specific Symptom Survey

Please mark any boxes that apply to you and your history

Currently Have	Had for a while but went away	Never Had	
☐	☐	☐	Agitation. Irritability, restlessness, or anxiety
☐	☐	☐	Balancing issues
☐	☐	☐	Bite problems
☐	☐	☐	Braces
☐	☐	☐	Breathing problems
☐	☐	☐	Blurred vision/ double vision
☐	☐	☐	Chronic sinusitis infection Seasonal? Yes __ NO__
☐	☐	☐	CPAP Machine
☐	☐	☐	Confusion
☐	☐	☐	Delayed communication, processing, or response times
☐	☐	☐	Dental implants
☐	☐	☐	Dental retainer
☐	☐	☐	Decreased Libido (sex drive)
☐	☐	☐	Disinhibition, impulsivity, or otherwise inappropriate behavior
☐	☐	☐	Difficulty sleeping
☐	☐	☐	Difficulty doing Math (adding up numbers, etc.)
☐	☐	☐	Dizziness
☐	☐	☐	Dry Eyes
☐	☐	☐	Ears plugged
☐	☐	☐	Eyes sensitive to light
☐	☐	☐	Fainting Spells
☐	☐	☐	Feel depressed.
☐	☐	☐	Feel like a fog or like the world is moving faster than you
☐	☐	☐	Had tubes in your ears.
☐	☐	☐	Hearing loss
☐	☐	☐	Headaches
☐	☐	☐	Impaired Speech
☐	☐	☐	Inability to control anger, aggression, or explosive behavior.

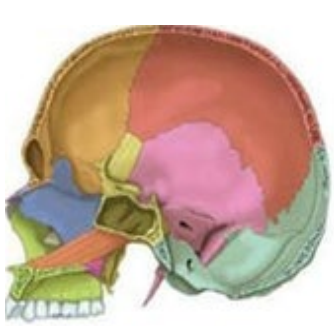
Currently have	Had for a while but went away	Never Had	
☐	☐	☐	Impatient or get angry more often
☐	☐	☐	Jaw Clicking
☐	☐	☐	Jaw Popping
☐	☐	☐	Lack of energy or get tired more easily
☐	☐	☐	Lack of planning, judgment, insight, or reasoning skills
☐	☐	☐	Loss of appetite
☐	☐	☐	Loss of smell
☐	☐	☐	Loss of taste
☐	☐	☐	Mouth breathing
☐	☐	☐	Nausea/ vomiting
☐	☐	☐	Poor coordination or muscle control
☐	☐	☐	Ringing in ear? If so, circle which: Right ear / Left ear / both ears
☐	☐	☐	Sleep apnea
☐	☐	☐	Snoring
☐	☐	☐	Speech problems (turning words around)
☐	☐	☐	Teeth clenching
☐	☐	☐	TMJ/TMD (Jaw problems)
☐	☐	☐	Unsteady gait or difficulty walking
☐	☐	☐	Difficulty sleeping

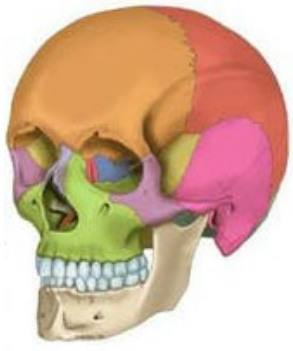
Please circle the appropriate number on this scale

(No Pain) **1 2 3 4 5 6 7 8 9 10** (Worst Pain Imaginable)

Use the letters below to indicate areas on your head where you are experiencing any of these symptoms

Th= Throb
A= Ache
P= Pressure
T= Tension
PL= Pulsing





Please Go to Page 3:

Bilateral Nasal Specific Consent: Dr. Siegfried recommends the Bilateral Nasal Specific treatment for me. I have consulted with him; have had all my questions answered regarding this treatment and I have chosen to proceed with it. I realize that he cannot guarantee results and understand that temporary pain may be involved. However, he will do the best he can to provide a satisfactory outcome for me. Dr. Siegfried is out of network and I understand that my insurance may not cover any of this procedure and agree to pay Dr. Siegfried his normal fee. I understand that if I seek insurance reimbursement for the treatment from my insurance company, the treatment may not be covered under my insurance plan.

Consent to Treat: Although Doctor will do his best to help me, I also understand that no cures are promised or implied and any risks regarding care at this office will be explained to me upon my request. I now authorize the Doctor to proceed with any necessary treatment after all my questions have been answered. I have read the clinic's office policies and consent to treat information. No information from my care here will be released to anyone without my written consent according to the HIPPA laws

Name (Print): _____

Signature: _____

Date: _____

Parent/Guardian's (required if patient is a minor):

Print: _____

Signature: _____

Date: _____

Thank you kindly for taking your time to fill out these forms.
We look forward to helping you and earning your referrals!

Dedicated to Your Health and Wellness,