Dunn Chiropractic Clinic
A Pain & Wellness Practice Since 1922

George Siegfried, D.C.
Chiropractic Physician
Since 1983
301 NE Dunn Place
McMinnville, OR 97128
Ph: 503-472-6550
Fax: 503-472-1039
www.nasalspecific.com
www.oregonwellnesscare.com

Welcome to the Clinic!

Thank you for taking time to fill out this form. Doctor hates paperwork too!! But it will save time and help him decide if you are a candidate for this most unusual and helpful natural, non-surgical treatment.

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? Y ☐ **N** ☐ **Were you happy with your care?** _____
Have you ever had a Bilateral Nasal Specific Treatment? Yes ☐ **No** ☐
Have you been to my website (*www.nasalspecific.com*)? Yes ☐ **No** ☐
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:
_____
Do you know if you had a long or difficult birth or were a C-Section or Vacuum Suction, etc.? Yes ☐ No ☐ Don't know. ☐

Please turn the page

Have you had any x-rays, CT or MRI scan(s) of your sinuses, or head? Yes ☐ No ☐
If yes, do you know where they were taken?

_____

Are you taking any of the medicines listed below or other medicines?
Flonase / Sudafed /Afrin / Zyrtec/ Claritin/ Other(s): _____

Are you taking any supplements? Yes No If yes, please list them: _____

_____

Are you taking Vitamin C? Yes ☐ No ☐ If yes, how much: _____

_____

Please write any additional symptoms or information that you would like to share with Dr. Siegfried:

_____

_____

Bilateral Nasal Specific Symptom Survey

Please mark any boxes that apply to you and your history

	Currently Have	Had but went away	Never Had
Agitation, irritability, Restlessness, or Anxiety			
Allergies, Seasonal? Or all the time?			
Bite Problems			
Bloody Nose			
Braces			
Breathing Issues			
Chronic Sinusitis Infection, Seasonal? Yes No			
Cognitive Disorders			
Concussion, Traumatic Brain Injury			
Confusion			
CPAP Machine			
Delayed Communication, Processing, or Response Times			
Dental Implants			
Dental Retainer			
Decreased Libido (sex drive)			
Depressed			
Difficulty Concentrating, Forgetfulness			
Difficulty Going to Sleep			

Please turn the page

Difficulty Staying Asleep			
Disinhibition, Impulsivity, or Inappropriate Behavior			
Difficulty Doing Math (adding up numbers, etc.)			
Dizziness			
Dry Eyes			
Dyslexia			
Ear infections			
Ears Plugged			
Eyes Sensitive to light			
Fainting Spells			
Foggy Brain			
Had Tubes in Your Ears			
Jaw Clicking			
Jaw Popping			
Lack of Energy, get tired easily			
Lack of Planning, Judgment, Insight or Reasoning Skills			
Loss of Appetite			
Memory Problems. Long Term? Short Term?			
Migraines			
Mouth Breathing			
Nasal Congestion			
Nausea/Vomiting			
Poor Coordination or Muscle Control			
Ringing in Ear? Which One?			
Sleep Apnea			
Snoring			
Speech Problems (turning words around)			
Teeth Clenching			
TMJ/TMD (Jaw Problems)			
Unsteady Gait or Difficulty Walking			
Vision Problems? What Kind?			

Any others not mentioned, please list:

_____

_____

Please turn the page

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

Bilateral Nasal Specific Consent to treat:. I have consulted with Dr. Siegfried and have had all my questions answered regarding this treatment and I have chosen to proceed with any necessary treatment. I realize that he cannot guarantee results and I understand that temporary pain may be involved, and any risks regarding this procedure will be explained to me upon request. However, he will do his best so that he can provide a satisfactory outcome for me. No cures are promised or implied.

I understand that Dr. siegfried is out of network and I understand that my insurance may not cover or reimburse any of this procedure and agree to pay Dr. Siegfried his normal fee.
Finally, no information from my care here will be released to anyone without my written consent according to HIPPA laws.

Name (Print): _____

Signature: _____

Date: _____

Parents/Guardians (required if patient is a minor):

Print: _____

Signature: _____

Date: _____

Please turn the page