

## *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](http://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.

**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:**

---

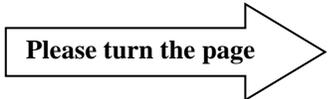


---

## **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			



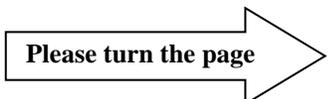
Difficulty Staying Asleep			
Disinhibition, Impulsivity, or Inappropriate Behavior			
Difficulty Doing Math (adding up numbers, etc.)			
Dizziness			
Dry Eyes			
Dyslexia			
Ear infections			
Ears Plugged			
Eyes Sensitive to light			
Fainting Spells			
Foggy Brain			
Had Tubes in Your Ears			
Jaw Clicking			
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 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: \_\_\_\_\_

