



Dear Patient,

Thank you for choosing OsteoMed II as part of your journey to optimal health. It is our intent to provide you with a personal and informative consultation in a friendly and comfortable environment.

We sometimes need to perform elective procedures that may not be covered entirely by insurance or healthcare reimbursement programs.

For all services, we require payment in full at time of service. We accept cash, check, Master Card, Visa and Discover Card.

How do you plan to pay for your treatments? (Check all that apply)

- Cash
- Check
- Credit Card

We look forward to serving you.

Best of Health,

Melissa Hammad  
General Manager



7271 Engle Road, Suite 115  
Middleburg Heights, Ohio 44130

\_\_\_\_\_  
**Last Name**

\_\_\_\_\_  
**First Name** **MI**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City** **State** **Zip**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Work**

**Sex:**  Male  Female

**Marital Status:**  Married  Single  Other

\_\_\_\_\_  
**Birthdate**

\_\_\_\_\_  
**Occupation**

\_\_\_\_\_  
**Employer**

*(Substitute parent information below if patient is a minor)*

\_\_\_\_\_  
**Responsible Party**

\_\_\_\_\_  
**Birthdate**

\_\_\_\_\_  
**Employer**

\_\_\_\_\_  
**SSN**

\_\_\_\_\_  
**Insurance Carrier**

\_\_\_\_\_  
**Policy/Group No.**

**How did you hear about us?**  
 Radio  
 Newspaper  
 TV Commercial  
 \_\_\_\_\_

**PATIENT INFORMED CONSENT**

1.) Acknowledgement – Notice to all Medicare Subscribers

Please be advised that OsteoMed II and its physicians do not accept assignment for Medicare. Therefore, Medicare may not cover the expenses for services they feel are medically unnecessary. Medicare does not recognize medical acupuncture, homeopathy or nutritional counseling, electro-acupuncture, chelation therapy or Prolotherapy for tendons and ligaments.

Although I may not be reimbursed for the above medical/surgical services, I desire the services to be performed by a physician of OsteoMed II and I agree to pay for the above medical/surgical services if payment is denied by Medicare, now and in the future.

2.) General Disclaimer Regarding Non-Toxic Therapy

Homeopathy, acupuncture, electro-acupuncture, Chinese herbal therapy, nutritional counseling, bioenergetic medicine, food allergy testing, Osteopathic manipulation and some instrumentation may not be recognized by some insurance companies, the Food & Drug Administration or traditional medicine as reimbursable or acceptable. Nevertheless, in expressing my constitutional right of freedom of choice of medical care, I choose to be diagnosed and treated by physicians of OsteoMed II.

RELEASE OF INFORMATION

I hereby give authorized release of my medical information to the physician(s) at OsteoMed II has referred to me to, or any person designated by me, and to my insurance carriers.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian if minor



## Allergy Elimination Patient Agreement

1. I understand that the allergy elimination techniques performed at OsteoMed II have been demonstrated to be effective 80-95% of the time.
2. I understand that this means that the treatments will either eliminate my allergy symptoms or produce satisfactory improvement in 80-85 out of 100 patients.
3. I understand that this method requires a series of treatments. I understand that for most patients, 10-15 treatments will be needed. Failure to continue treatment after one or two sessions could make my symptoms worse.
4. I understand that occasionally my symptoms may worsen after a treatment and that previously unknown allergies may appear during the course of the treatment (by "unmasking"). Occasionally an allergen may need to be re-treated to make the symptoms subside.
5. I understand that I may have to repeat the treatment for one or more allergens if that allergen does not clear on a single visit. I understand that the repeat treatment is due to the intensity of the allergen in my body and not due to the fault of the treating staff. I understand that the repeat treatments will be billed as a regular visit (\$90 for the office visit plus \$65 for each allergy treatment).
6. Understanding all of the items above, I wish to proceed with the allergy elimination treatments given by the OsteoMed II staff. By signing this agreement, I am stating that I clearly understand the above information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_



**OsteoMed II**  
*Progressive Medicine*

7271 Engle Road, Suite 115  
Middleburg Heights, OH 44130  
(440) 239-3438

### **Emergency Services**

OsteoMed II provides a variety of health services on an outpatient basis. Sherri Tenpenny D.O., R.C. Walsh Jr. D.O., Cindy Fraed, M.D., and Sandi Asazawa, PA and or Paula Vetter, NP are not primary care providers and do not admit patients to the hospital. Patients must have a regular physician for routine medical problems. If an urgent situation should arise outside of regular office hours, you may attempt to reach **Dr. Tenpenny** on her cell phone at **(440) 263-0405** or **Dr. Walsh** on his beeper at **(330) 560-5508**. If the doctor cannot be reached, patients should call their primary care physician or go to the nearest emergency room or urgent care facility.

I have read and understand the above statement regarding the restriction of medical services outside regular office hours.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Medical Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

# Health History Sheet

Name: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

DOB: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**Please list all illnesses, hospitalizations, emotional traumas  
(depression, death, etc.) The more detailed, the better.**

Birth - 1 yr \_\_\_\_\_ 19 yr - 29 yr \_\_\_\_\_

\_\_\_\_\_

2 yr. - 5 yr. \_\_\_\_\_ 30 yr - 39 yr \_\_\_\_\_

\_\_\_\_\_

6 yr. - 8 yr. \_\_\_\_\_ 40 yr - 49 yr \_\_\_\_\_  
(grade school)

\_\_\_\_\_

9 yr. - 12 yr. \_\_\_\_\_ 50 yr - 59 yr \_\_\_\_\_

\_\_\_\_\_

13 yr. - 18 yr. \_\_\_\_\_ 60 + \_\_\_\_\_  
(high school)

\_\_\_\_\_

Occupation \_\_\_\_\_ Highest level of education \_\_\_\_\_

## Family History

	Good	Poor	Deceased	Medical Problems	Anything Unusual
Father					
Mother					
Brother(s)					
Sister(s)					

**Please indicate (approx.) year of your last:**

Complete Physical Exam \_\_\_\_\_ Sigmoidscopy \_\_\_\_\_ Cardiac Stress Test \_\_\_\_\_

Chest X-ray \_\_\_\_\_ Others \_\_\_\_\_ Heart catheterization \_\_\_\_\_

Kidney X-ray \_\_\_\_\_ CAT/MRI \_\_\_\_\_ Tetanus \_\_\_\_\_

Stomach X-ray \_\_\_\_\_ \_\_\_\_\_ Influenza \_\_\_\_\_

Colon X-ray \_\_\_\_\_ \_\_\_\_\_ DPT \_\_\_\_\_

Gallbladder X-ray \_\_\_\_\_ Electrocardiogram \_\_\_\_\_ TB Test \_\_\_\_\_

# Energetic History

At what time of day or night are your symptoms worse?

AM       PM

Do you prefer to be: inside?

or to be outside?

Do you sleep well?      Yes       No

If no, elaborate: \_\_\_\_\_

What is your average energy level?

Low 1 2 3 4 High

What makes your symptoms better? \_\_\_\_\_

Worse? \_\_\_\_\_

What was the most significant medical or emotional occurrence in your life? \_\_\_\_\_

On a scale of 1-10, what do you rate your present stress level? 1 2 3 4 5 6 7 8 9 10

What is your greatest fear? \_\_\_\_\_

What really makes you happy? \_\_\_\_\_

Do you tend to feel hot or cold? \_\_\_\_\_

## Nutritional History

List typical daily diet:

Breakfast	Lunch	Dinner	Snacks

What do you crave to eat? \_\_\_\_\_

Do you feel sleepy or tired after eating? \_\_\_\_\_

Do you have any digestive problems? \_\_\_\_\_

Are you able to fast for 12-24 hours without symptoms? \_\_\_\_\_

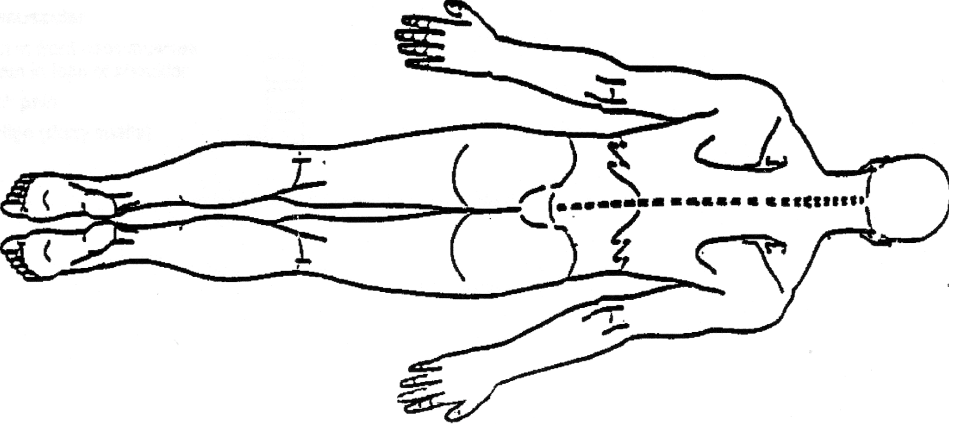
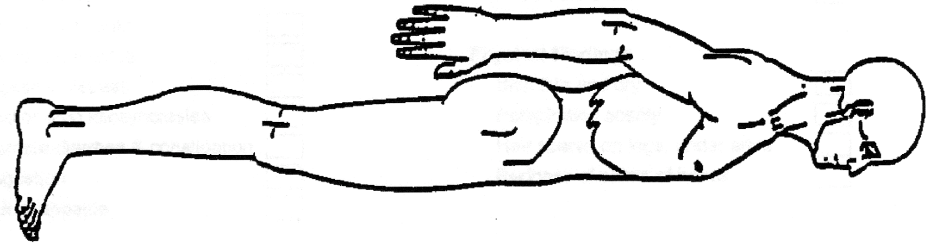
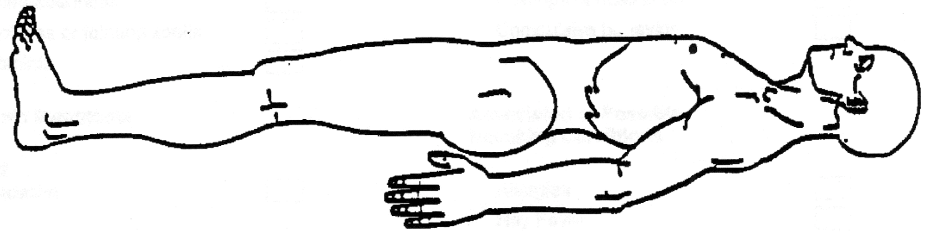
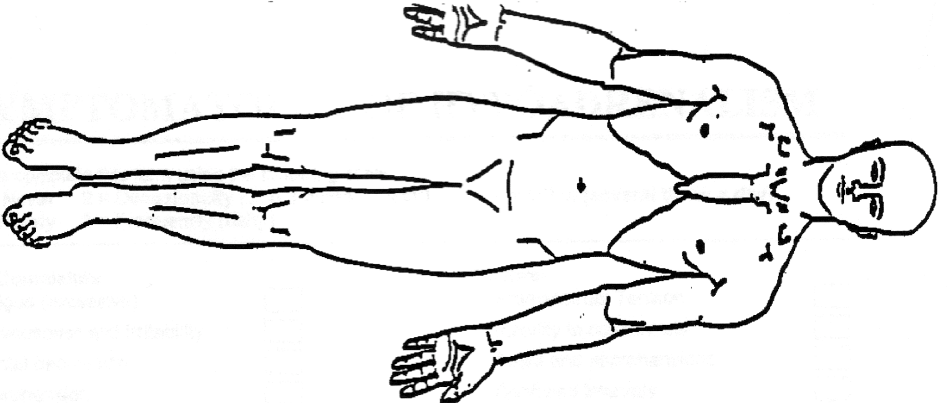
Do you have regular bowel actions? \_\_\_\_\_

How often do you consume the following?

1 = Frequent    2 = Often    3 = Occasionally    4 = Seldom    5 = Never

- |                        |                            |                      |
|------------------------|----------------------------|----------------------|
| Alcohol _____          | Fried foods _____          | Sugar/desserts _____ |
| Black Tea _____        | Frozen/canned food _____   | White flour _____    |
| Butter _____           | Organic grains _____       | Whole grains _____   |
| Cheese _____           | Beans _____                |                      |
| Chips _____            | Mayonnaise _____           |                      |
| Coffee _____           | Margarine _____            |                      |
| Eggs _____             | Meats (fish/poultry) _____ |                      |
| Excessive eating _____ | Milk _____                 |                      |
| White rice _____       | Eating out _____           |                      |
| Fast food _____        | Pkgd/proc. foods _____     |                      |
| Fresh fruit _____      | Soda _____                 |                      |
| Fresh veg. _____       | Salt _____                 |                      |





Mark area(s) of pain on diagram above

Note: Please use the following key:

- Ache: ///
- Burning: BBB
- Numbness: XXX
- Pins/needles: ====
- Stabbing: ZZZ
- Other: OOO

# Symptomology of Hypoadrenalism

Please complete this form using the following scale:

0 = Never

3 = Frequently (daily)

1 = Rarely

4 = Often (several x/day)

2 = Occasionally (2-3x/week)

## Chief Complaints

- Fatigue (excessive)
- Nervousness and irritability
- Mental depression
- Apprehension
- Weakness (excessive)
- Lightheadedness
- Faintness or fainting spells
- Insomnia

## Systemic Symptoms

- Headache

## Cardiovascular

- Irregular beats
- Racing heartbeat

## Gastrointestinal

- Craving for sweets
- Alcohol intolerance
- Epigastric distress
- Food or drug idiosyncrasies
- Alternate diarrhea and constipation
- Indigestion
- Lack of appetite

## Neuromuscular

- Pain in front neck muscles
- Pain in tops of shoulders
- Back pain
- Vertigo (dizzy spells)

## Cerebral

- Premenstrual tension
- Inability to concentrate
- Fears and apprehensions
- Confused intervals
- Poor memory
- Feelings of frustration
- Compulsive behavior

## Associated or Possible Resulting Conditions

- Allergies
- Hay fever
- Hives
- Asthma
- Psoriasis-Eczema
- Heat sensitivity
- Rheumatoid arthritis

## Physical Findings

- dry and thin skin
- Perspiration scanty
- Hair sparse on legs, under arms
- Redness on palms of hands

**Please circle if currently having any of these symptoms  
Please (✓) if you've had any symptoms in the last year**

**General**

- Allergies
- Alcohol problems
- Cancer
- Chronic fatigue
- Congenital birth defects
- Blood transfusion
- Weight gain
- Weight loss
- Drug addiction
- Diabetes
- Hypoglycemia
- Other

**Thyroid**

- Feel cold
- Constipation
- Dry skin
- Fatigue
- Inability to lose weight
- High cholesterol
- Anemia
- Goiter
- Other

**Cardiovascular**

- Hypertension
- Heart attack
- Bypass surgery
- Heart murmur
- Irregular heartbeat
- Blood clots/phlebitis
- Ankle swelling
- Angina
- Cannot sleep lying flat
- High cholesterol
- Palpitations
- Leg cramps when walking
- Other

**Musculoskeletal**

- Pain - location \_\_\_\_\_
- Osteoporosis
- Neck strain
- Low back strain
- Fractures \_\_\_\_\_
- Back surgeries \_\_\_\_\_
- Swollen joints
- Scoliosis
- Joint stiffness
- Muscle weakness

**Head**

- Headaches
- Recurrent sore throat
- Sinusitis
- Nose bleeds
- Mouth sores

- Hair loss
- Head injury
- Deafness
- Eye problems
- Recurrent ear infections
- Meningitis
- Other

**Dental Problems**

- Dentures
- Braces
- Jaw locking, popping
- Salivary gland problems
- Jaw pain
- Snoring
- Extractions
- Other

**GI Tract**

- Appendicitis
- Always hungry
- Bloating
- Irritable bowel
- Constipation
- Diverticulitis
- Excess bleeding
- Rectal fissures
- Excess rectal gas
- Gallbladder disease
- Jaundice
- Cirrhosis
- Polyps
- Hernia
- Hemorrhoids
- Pancreatitis

**Nervous System**

- Numbness
- Dizziness
- Spinning sensation
- Imbalanced when walking
- Concussion
- Stroke
- Mini stroke
- Limb paralysis/weakness

**Mental Status**

- Depression
- Chronic anxiety
- Suicide attempts
- Mental illness
- Dyslexia
- ADD
- Bulimia
- Anorexia
- Nervous breakdown
- Difficulty sleeping
- Insomnia

**Other**

**Respiratory**

- Asthma
- Emphysema
- COPD
- Recurrent colds
- Bronchitis
- Pneumonia
- Hay fever
- Other

**GU System**

- Recurrent bladder infection
- Difficulty urinating
- Prostate problems
- Testicular problems
- Kidney stones
- Sexual dysfunction
- Candida/Yeast infections
- Other

**Infections**

- Strep throat (recurrent)
- Scarlet fever
- Rheumatic fever
- Epstein Bar virus
- Tuberculosis
- Syphilis
- Shingles
- Mononucleosis
- Hepatitis
- Mumps
- Measles
- Chickenpox
- Polio
- Herpes - location \_\_\_\_\_
- Other

**Women**

- Date of last pap smear \_\_\_\_\_
- Age of 1st period \_\_\_\_\_
- Usual length \_\_\_\_\_
- Number of pregnancies? \_\_\_\_\_
- Number of children? \_\_\_\_\_
- Menstrual cramps? \_\_\_\_\_
- PMS symptoms? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Regular periods? \_\_\_\_\_
- Date last mammogram? \_\_\_\_\_
- Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Today's date: \_\_\_\_\_

Your name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_

State:

Email address: \_\_\_\_\_

Whom may we thank for referring you?

Patient referral (name) \_\_\_\_\_

Doctor referral (name) \_\_\_\_\_

Osteomed II website

NMA website

Other website

E-newsletter

Direct mail

Seminar (topic) \_\_\_\_\_

TV (show) \_\_\_\_\_

Radio (show) \_\_\_\_\_

Other (please list source) \_\_\_\_\_

What services will we be providing for you today?

Allergy elimination

Women's health

Children's Health

Asthma

Specialized tests

Thyroid

Pain

Fibromyalgia

Sleep issues

Thermography

Gynecological

Which practitioner are you scheduled to see:

Dr. Tenpenny

Sandi Asazawa

Dr. Walsh

Paula Vetter

Dr. Fraed

Linda Corlett

Gail/Carol (thermography)

Thank you for taking the time to help us. Please return all forms to our receptionist.