

Bio Energy Medical Center

Account Information

Please print clearly in blue or black ink

Please give this to the front desk receptionist when checking in for your visit

Patient's Information

Patient's Name: _____ Phone: () _____

Work Phone: () _____ Cell Phone: () _____ E-Mail _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security Number: _____ - _____ - _____

**If patient is a minor:* Parent/Guardian Name: _____ Relation: _____

Parent/Guardian SSN: _____ - _____ - _____ Date of Birth: ____/____/____

How did you hear about BEMC? _____

Employer and Spouse Information

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Emergency Contact Name and Relationship: _____

Emergency Contact: Phone Number: () _____ Alternate: () _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information (please give card at front desk)

Insurance Company: _____

Name on Card: _____ Patient's Relation: *Self* [] *Spouse* [] *Child* []

Contract/ID Number _____ Policy/Group Number _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Benefits Phone Number: () _____ (This info can be found on the back of card)

MEDICAL HISTORY

Height: _____ Weight: _____

Are you currently under the care of a physician? _____

Physician's Name: _____ City: _____ State: _____

Dentist's Name: _____ City: _____ State: _____

Other Care Providers: _____

Are you currently being treated for any health problems? _____

Diagnosis and date: _____

What specific problem brought you to the center today? _____

Provide a brief description of symptoms, diagnoses received and current treatment methods:

What do you think caused your health problems? _____

Provide a brief description of childhood and adult illnesses and operations:

Operations: Date/Age: Type of Operation: Reason:

Childhood Illnesses: Date/Age: Diagnosis: Recovery:

Adult Illnesses: Date/Age: Diagnosis: Recovery:

Have you been immunized? _____ List immunizations: _____

Do you have allergic reactions to any medications? Indicate:

Medication: Reaction:

Please list all medications you are currently taking: _____

SYMPTOM SURVEY

Please check the symptoms that describe your health now and in the past.

Symptom	Now	Past	Symptom	Now	Past	Symptom	Now	Past
Head Problems	[]	[]	Digestion Problems	[]	[]	Elimination Problems	[]	[]
Sinus	[]	[]	Weight Loss	[]	[]	Vomiting	[]	[]
Allergies/Hives	[]	[]	Weight Gain	[]	[]	Diarrhea	[]	[]
Hay Fever	[]	[]	Loss of Appetite	[]	[]	Constipation	[]	[]
Dizziness	[]	[]	High Blood Sugar	[]	[]	Yeast/Candida Infection	[]	[]
Visual Problems	[]	[]	Low Blood Sugar	[]	[]	Urinary Tract Problems	[]	[]
Hearing Problems	[]	[]	Abdominal Pain	[]	[]	Lymphatic System Problems	[]	[]
Taste Problems	[]	[]	Abdominal Spasms	[]	[]	Breast Problems	[]	[]
Speech Problems	[]	[]	Abdominal Bloating	[]	[]	Skin Problems	[]	[]
Throat Problems	[]	[]	Belching/Burping	[]	[]	Fluid Retention	[]	[]
Bronchitis	[]	[]	High Cholesterol	[]	[]	Congestion in:		
Asthma	[]	[]	Protein Digestion	[]	[]	__Throat __Head		
Emphysema	[]	[]	Carbohydrate Digestion	[]	[]	__Lungs __Nose		
Circulatory Problems	[]	[]	Fat Digestion	[]	[]	Mental/Emotional	[]	[]
High Blood Pressure	[]	[]	Reproductive Problems	[]	[]	Confusion	[]	[]
Low Blood Pressure	[]	[]	Menstrual Problems	[]	[]	Anxiety	[]	[]
Heart Problems	[]	[]	PMS	[]	[]	Irritability	[]	[]
Irregular Pulse Rate	[]	[]	Irregular Menses	[]	[]	Heaviness	[]	[]
Nerve Problems	[]	[]	Heavy Flow	[]	[]	Lightness	[]	[]
Touch Problems	[]	[]	Severe Pain	[]	[]	Loss of Concentration	[]	[]
Coordination Problems	[]	[]	Gynecological Problems	[]	[]	Loss of Memory	[]	[]
Movement Problems	[]	[]	Obstetrical Problems	[]	[]	Phobias/Fears	[]	[]
Sensitive Hot&Cold	[]	[]	Aches/Pains/Stiff in:			Sleep Disorders	[]	[]
Pain in Spinal Cord	[]	[]	__Hands__Arms__Neck			Fatigue	[]	[]
Muscle / Tendon / Ligament	[]	[]	__Feet__Legs__Hips			Communication Problems	[]	[]
Joint Problems	[]	[]	Other:					

SYMPTOM SURVEY: COLON FUNCTION

How often do you have bowel movements? ____ Times per Day ____ Times per Week

Indicate what type of bowel movements you have and how often they occur:

TYPE	FREQUENTLY	OCCASIONALLY	NEVER
Diarrhea	[]	[]	[]
Constipation	[]	[]	[]
Mucous	[]	[]	[]
Undigested Food	[]	[]	[]
Gas/Flatulence	[]	[]	[]
Blood in B.M.	[]	[]	[]
Painful B.M.	[]	[]	[]

Do you have a medical history of colon problems?

<input type="checkbox"/> Colitis	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Obstruction
<input type="checkbox"/> I.B.S.	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:	

Have you ever had abdominal surgery?

Type: _____ Date: _____ Recovery: _____

Have you noticed any significant changes in your colon's bowel habits within the last

Month: _____ 2 months: _____

3 months: _____ Other: _____

Do you use any laxatives? _____ Brand: _____ Frequency: _____

Do you give yourself enemas? _____ How often? _____

Have you ever had colonics? _____ When? _____

Name of your colon therapist: _____

SIGNIFICANT LIFE EVENTS

(Health, School, Relationships, Jobs, Births, Deaths, etc.)

Age 0-5 _____

Age 6-10 _____

Age 11-15 _____

Age 16-20 _____

Age 21-25 _____

Age 26-30 _____

Age 31-36 _____

Age 37-40 _____

Age 41-45 _____

Age 46-50 _____

Age 51-55 _____

Age 56-60 _____

Age 61-65 _____

Age 66-70 _____

Age 71-75 _____

Age 76+ _____

Bio Energy Medical Center

Informed Consent

The purpose of this consent is to document an understanding between the Bio Energy medical Center and its clients. By signing this document, the client understands and accepts the following points:

- Although Dr. Neuenschwander is an Allopathic physician, the treatment protocols follow the sciences of Acupuncture, Homeopathy, and Naturopathic Medicine and are not considered the standard of medical care. The client agrees to accept the attendant risks associated with an alternative approach. Standard Allopathic services can be provided at the client's request.
- Treatment at Bio Energy Medical Center involves a team approach, and the client understands that his/her case may be discussed at team meetings unless prior arrangements are made. As always, any information will be treated in a professional and confidential manner.
- Bio Energy Medical Center will submit insurance billing. However, clients are ultimately responsible for any charges incurred. Unless other arrangements have been made, payment is expected at the time of service for the following: products, insurance co-pays and deductible payments, patients without insurance coverage, or insurance coverage that does not cover our services.
- Information requested from an insurance company that may be needed to result in payment will be released.
- The client understands that certain treatments may not be covered or considered billable under his/her insurance plan. In this case, the client is responsible for payment.
- The Bio Energy Medical Center operates in an environment of trust and finds malpractice insurance an obstruction to this environment; therefore, it does not carry insurance. If this raises an issue for the client, he/she agrees to resolve this in some way prior to treatment being rendered.

By signing this document, the client understands and agrees to its provisions.

Date: ____ / ____ / ____ Client: _____

Witness: _____

HIPAA Consent

I am aware that a document containing my privacy rights under the HIPAA laws is available in the Bio Energy Medical Center waiting room should I wish to review it. By signing this document, I am signifying that I understand and agree to its provisions.

Date: ____ / ____ / ____ Client: _____

Witness: _____

I.V. POLICY

The policy on payment for I.V.'s is as follows:

1. Payment is paid at 100% at time of visit unless the patient has been instructed otherwise.
2. Payment is paid at 100% at time of visit even if the I.V. is not administered for whatever reason.
3. Cancellations made without 24-hour notice and no-show patients pay 100%

By signing this document, the client understands and agrees to its provisions.

Date: ____ / ____ / ____

Client: _____

Witness: _____