Dr. Tamzon D. Feeney, D.O., LLC
Osteopathic Physician: Neuromusculoskeletal and
Cranial Sacral Osteopathic Medicine

Environmental History

Patient Name: _____ Date: _____

1. Do you have any allergies (drug, fiber, pets, food, pollen, plants, dust, etc.)? ☐ Yes ☐ No
   If yes, please list in the space provided below.

2. Is there anything in your life or environmental past or present that may have contributed to your present complaint (allergies, furnishings, home, temperature, emotions, pressures, people, problems, responsibilities, physical emotional or sexual abuse, etc…)? ☐ Yes ☐ No
   If yes, please list in the space provided below.

3. Are there things that seem to make your problems worse? ☐ Yes ☐ No
   If yes, please list in the space provided below.

4. Are there things that make your problem better? ☐ Yes ☐ No
   If yes, please list in the space provided below.

5. Have there been major changes in your life in the past couple of years? ☐ Yes ☐ No
   If yes, please list all that you can think of in the space provided below (death, divorce, marriage, accident, physical/emotional/sexual abuse, job changes, good or bad financial changes, renovations of living quarters, birth, adoption, or change of the # of people living in your household, moves, pets, travels, or vacations in our outside of the USA, dietary changes, weight gain or loss, etc.).

6. We would appreciate your sharing with us some of the things you worry about most. Use the back and add paper if necessary.

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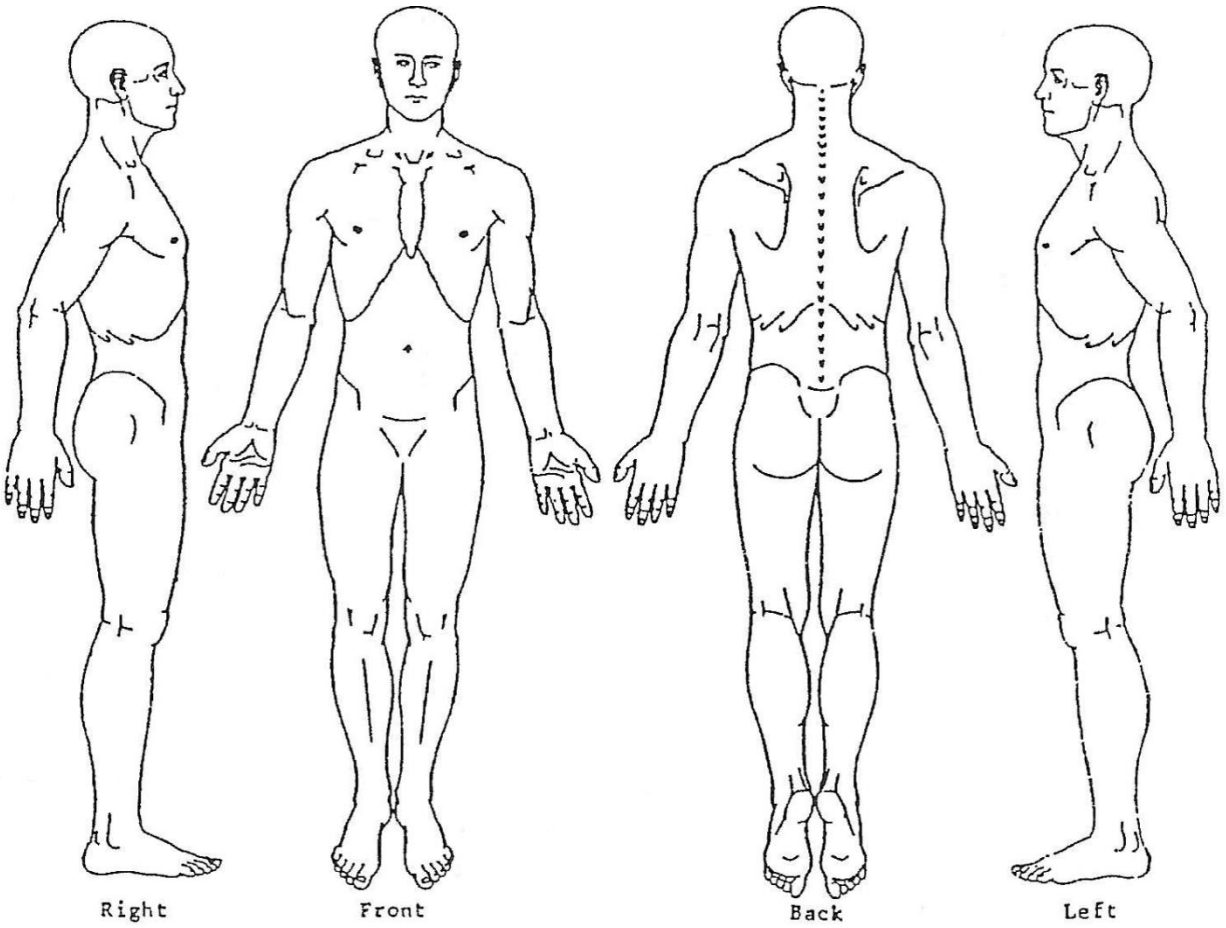
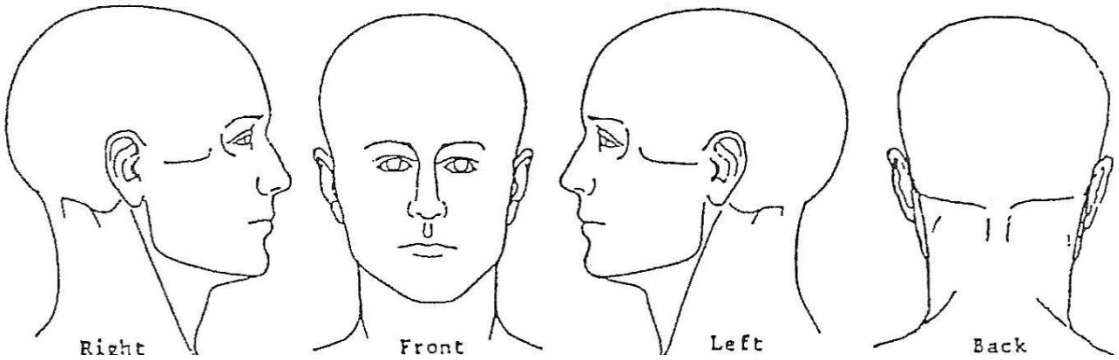
Diagrams of Body & Head Symptoms

Patient Name: _____ Date: _____

1. Indicate on the diagrams the location of your symptoms. Shade or color the areas.
2. If your problem radiates or moves from one location to another, indicate with arrows.
3. If you have problems in several locations, indicate each area with a severity on a scale of 1-10, with 1 being the least sever and 10 being the most severe pain you have ever experienced.
4. If you have any scars on your body, please indicate the locations with solid lines.





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Candida Albicans Score Sheet

Patient Name: _____ Date: _____

Troubled by or involved with, in the PAST or PRESENT (check symptoms which apply to you).

☐ Confusion	☐ Insomnia	☐ Dizziness	☐ No energy
☐ Fatigue	☐ Feeling drained	☐ Irritable	☐ Forgetfulness
☐ Depression	☐ Feeling spacey	☐ Hyperactive	☐ Nervous breakdown
☐ Poor memory	☐ Unable to concentrate	☐ Lethargic	☐ Disturbance with smell
☐ Agitation	☐ Mood swings	☐ Drowsiness	☐ Disturbance with taste

☐ Digestive problems	☐ Gas	☐ Stools float	☐ Bad breath
☐ Constipation	☐ Belly aches	☐ Heartburn	☐ Vomiting
☐ Bloating	☐ Nausea	☐ Hemorrhoids	☐ Colitis
☐ Diarrhea	☐ Spastic colon	☐ Dry mouth	☐ Fluid retention

☐ Premenstrual tension	☐ Vaginal itching or burning	☐ Frequent urination or urgency	☐ Frequent sore throats
☐ Endometriosis	☐ Vaginal discharge		☐ Itchy watery eyes
☐ Recurrent prostatic inflammation	☐ Impotence	☐ Burning urination	Allergies
	☐ Loss of sexual feeling	☐ Frequent ear infections	
☐ Pregnancy	☐ Dysmenorrheal	☐ Mouth ulcers	

Crave or have craved:

☐ Sweets	☐ Carbohydrates	☐ Fruits	☐ Cheeses
☐ Breads	☐ Alcoholic beverages	☐ Nuts	☐ Dairy products

☐ Recurrent headaches	☐ Body aches	☐ Numbness or tingling	☐ Legs cramping
☐ Muscle or joint pain	☐ Muscle weakness	☐ Failing vision	

☐ Skin rashes	☐ Eczema	☐ Flaky skin	☐ Hair falling out
☐ Hives	☐ Itchy ears or rectum	☐ Acne	☐ Dandruff
☐ Psoriasis	☐ Dry skin	☐ Nasal itching	

☐ Thrush	☐ Nail infections	☐ Recurrent vaginal or bladder yeast infections
☐ Athlete's foot	☐ Skin infections (with peeling)	☐ Other fungal infection
☐ Jock rash		

Take or have taken:

☐ Antibiotic drugs	☐ Cortisone	☐ Tranquilizers
☐ Birth control pills	☐ Steroids	

Sensitive to:

☐ Tobacco	☐ Perfume	☐ Auto exhaust	☐ Fabrics
☐ Smoke	☐ Chemical odors	☐ Gas heat or stoves	☐ Insecticides

☐ Feel uncomfortable in moldy places or on muggy days	☐ Live near a water environment

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THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (*HIPAA*) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. "HIPAA" provides penalties for covered entities that misuse personal health information. This ACT gives you, the patient, significant new rights to understand and control how your health information is used.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records without asking for your express consent, only for each of the following purposes: treatment, payment, and health information.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

- Treatment means providing coordinating, or managing health care and related services by one or more health care providers. For example, a chiropractor may need to know the result of your latest physician's examinations or last treatment plan.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. We may also need to tell your insurance company about proposed treatment to determine whether or not it will be a covered treatment.
- For Health Care Operations including the business aspects of running a practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

II. SPECIFIC USES AND DISCLOSURES WITH YOUR AUTHORIZATION

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other use and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

III. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend, or other person identified by you. All requests for restrictions must be made in writing.
- We are not required to agree to your requested restriction (except that if you are competent you may restrict disclosures to family members or friends). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.
- You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive accounting of disclosures of protected health information.
- You have the right to obtain a paper copy of this notice from us upon request.

IV. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

You have recourse if you feel that your privacy protections have been violated. If you believe that your privacy rights have been violated, you have the right to file a complaint in writing with our office, the Department of Health and Human Services, or the Office of Civil Rights. We will not retaliate against you if you file a complaint.

V. CHANGES TO THIS NOTICE

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 15, 2003, and we are required to abide by the terms of the Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protocol health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

Signature: _____ Date: _____

Dr. Tamzon D. Feeney, D.O., LLC

Osteopathic Physician: Neuromusculoskeletal and
Cranial Sacral Osteopathic Medicine

Website: www.DocFeeney.com
Office address: 260 South First St., Suite 2, Zionsville, IN 46077

For appointments and questions contact:
Amy Fretz, B.S.N., R.N., Registered Nurse
317-914-9615 amymhere@gmail.com

What do we do?

We deal with complex medical issues of infants, children, and adults. Many patients feel they have fallen through the cracks of traditional medical care and we try to remedy this. We are committed to listening to your concerns and treating you in an honest and open way. Our focus is to assist you with chronic, long-term, difficult, or unusual problems for which you or your child has not been able to obtain any relief. Every patient is treated with Osteopathic manipulative techniques. Prescriptions for medicine are written when needed. Once you have seen Dr. Feeney you may be referred to someone who will test you for bioidentical hormone therapy and who will manage your care and prescriptions for hormones. We provide prescriptions for bioidentical hormones and Low Dose Naltrexone (LDN) for one year at a time. We do not provide medical care that you can routinely receive from your family doctor such as diabetes care, pap smears, well baby care, immunizations, and blood pressure monitoring. These are easily taken care of by other doctors. We do not perform routine laboratory tests; however, we do write prescriptions for some lab tests or x-ray testing. You can take these prescriptions to the lab or radiology department of your preference.

Payment, Insurance, and Legal Information

We do not take payment from any insurance companies, Medicare, or Medicaid. No government or corporation dictates how you can be best cared for. A receipt is provided with treatment codes that may be submitted to your insurance company but not to Medicare (Dr. Feeney has opted out of Medicare). We do not provide treatment for workers' compensation or legal cases. We do not write letters to lawyers or insurance companies. We will appear in court only under subpoena and we are not for hire as an expert witness. We take Visa or Mastercard, or personal check. We also offer a $20 discount for cash. (This discount does **not** apply to checks).

Cancellation Policy

If you must **cancel** an appointment within 24 hours of your appointment time please call Charles Askren at **317-679-3733**. If it is more than 24 hours ahead of time, call Amy Fretz at **317-914-9615.** If you fail to appear for an appointment without cancelling ahead of time, you will receive a bill for the lost treatment time. So please call ahead to cancel.

Preparing for your appointment

Please wear or bring loose, soft-fitting clothing to be treated in. Do not wear jeans. Except for examination of areas particular to your problem, you will not be required to undress.

I have received a copy of this information for my records.

Patient Name: _____ Date: _____

Signature: _____

Physician Copy

Dr. Tamzon D. Feeney, D.O., LLC

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I have received a copy of this information for my records.

Patient Name: _____ Date: _____

Patient Copy

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Osteopathic Physician: Neuromusculoskeletal and
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PRIVATE CONTRACT

This agreement is between Tamzon D. Feeney, D.O., whose principal place of business is 2204 W. 58th Street, Indianapolis, IN 46228, and:

Beneficiary: _____

Who resides at: _____

_____

_____

Medicare ID #: _____

is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on 7/18/2013. The physician is not excluded from participating in Medicare Part B under [1128]·1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands, and expressly acknowledges the following:

Please initial each line below

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on:

Date: _____

By Signed: _____

And:

_____
Dr. Tamzon D. Feeney, D.O.

Dr. Tamzon D. Feeney, D.O., LLC

Osteopathic Physician: Neuromusculoskeletal and
Cranial Sacral Osteopathic Medicine

ANNUAL HISTORY & PHYSICAL

DATE _____

NAME _____ S ☐ M ☐ W ☐ D ☐ INSURANCE # _____

ADDRESS _____ (H) _____ (O) _____

OCCUPATION _____ DATE OF BIRTH _____

FAMILY HISTORY If any blood relative has suffered any of the following – please indicate which relative.

EPILEPSY		DIABETES		ARTHRITIS		ALCOHOLISM		STROKE	
MIGRAINE		THYROID DIS.		GOUT		ASTHMA		HYPERTENSION	
MENTAL ILL.		BLEEDS EASILY		OSTEOPOROSIS		HAY FEVER		HEART DIS.	
GLAUCOMA		ANEMIA		KIDNEY DIS.		CANCER			

HOSPITAL ADMISSION

YEAR	ILLNESS OR OPERATION

YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TALKING		
DRUG ALLERGIES		

APPROXIMATE YEAR OF LAST IMMUNIZATION	PNEUMONIA		FLU	
	HEPATITIS		TETANUS	
	MEASLES		DIPHTHERIA	
	MUMPS		PERTUSSIS	
	RUBELLA		POLIO	

SYNOPSIS Describe How Your Chief Problem Started And Developed

MEDICAL HISTORY

MAIN PROBLEMS (1)_____ **(2)**_____
(3)_____

CHECK C FOR CURRENT OR P FOR PAST. IF PAST, INDICATE THE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

C	P	AGE		C	P	AGE	
☐	☐	____	DECREASED HEARING	☐	☐	____	VENEREAL DISEASE
☐	☐	____	RINGING IN EAR	☐	☐	____	URETHRAL DISCHARGE
☐	☐	____	EAR INFECTIONS - FREQUENT	☐	☐	____	CHRONIC FATIGUE
☐	☐	____	DIZZY SPELLS	☐	☐	____	WEIGHT LOSS - RECENT
☐	☐	____	FAILING VISION	☐	☐	____	ANEMIA
☐	☐	____	DOUBLE OR BLURRED VISION	☐	☐	____	BRUISE EASILY
☐	☐	____	EYE PAIN	☐	☐	____	CANCER
☐	☐	____	EYE INFECTIONS - FREQUENT	☐	☐	____	DIABETES
☐	☐	____	NOSE BLEEDS - RECURRENT	☐	☐	____	THYROID DISEASE
☐	☐	____	SINUS TROUBLE	☐	☐	____	CONVULSIONS / SEIZURES
☐	☐	____	SORE THROATS – FREQUENT	☐	☐	____	STROKE
☐	☐	____	HAYFEVER / ALLERGIES	☐	☐	____	TREMOR / HANDS SHAKING
☐	☐	____	HOARSENESS – PROLONGED	☐	☐	____	MUSCLE WEAKNESS
☐	☐	____	PNEUMONIA / PLEURISY	☐	☐	____	NUMBNESS / TINGLING SENSATIONS
☐	☐	____	BRONCHITIS / CHRONIC COUGH	☐	☐	____	HEADACHES - FREQUENT
☐	☐	____	ASTHMA / WHEEZING	☐	☐	____	ARTHRITIS / RHEUMATISM
☐	☐	____	SHORTNESS OF BREATH:	☐	☐	____	BACK PAIN - RECURRENT
			☐ ON EXERTION ☐ LYING FLAT	☐	☐	____	BONE FRACTURE / JOINT INJURY
☐	☐	____	CHEST PAIN	☐	☐	____	GOUT
☐	☐	____	HIGH BLOOD PRESSURE	☐	☐	____	FOOT PAIN
☐	☐	____	HEART MURMUR	☐	☐	____	COLD NUMB FEET
☐	☐	____	PALPITATIONS	☐	☐	____	RASHES
☐	☐	____	IRREGULAR PULSE	☐	☐	____	HIVES
☐	☐	____	SWOLLEN ANKLES	☐	☐	____	PSORIASIS
☐	☐	____	FAINTING SPELLS	☐	☐	____	ECZEMA
☐	☐	____	LEG PAIN WHEN WALKING	☐	☐	____	SLEEPING - DIFFICULTY
☐	☐	____	VARICOSE VEINS / PHLEBITIS	☐	☐	____	NERVOUSNESS
☐	☐	____	LOSS OF APPETITE (RECENT)	☐	☐	____	DEPRESSION
☐	☐	____	DIFFICULTY SWALLOWING	☐	☐	____	MEMORY LOSS
☐	☐	____	INDIGESTION OR HEARTBURN	☐	☐	____	MOODINESS – EXCESSIVE
☐	☐	____	PERSISTENT NAUSEA / VOMITING	☐	☐	____	PHOBIAS
☐	☐	____	PEPTIC ULCERS	☐	☐	____	MENTAL ILLNESS
☐	☐	____	ABDOMINAL PAIN (CHRONIC)	☐	☐	____	CHICKEN POX
☐	☐	____	CHANGE IN BOWEL HABITS (RECENT)	☐	☐	____	POLIO
☐	☐	____	DIARRHEA	☐	☐	____	MEASLES
☐	☐	____	CONSTIPATION	☐	☐	____	GERMAN MEASLES
☐	☐	____	DIVERTICULOSIS	☐	☐	____	RHEUMATIC
☐	☐	____	BLOODY OR TARRY STOOLS	☐	☐	____	SCARLET FEVER
☐	☐	____	HEMORRHOIDS	☐	☐	____	MUMPS
☐	☐	____	GALL BLADDER TROUBLE	☐	☐	____	TUBERCULOSIS
☐	☐	____	JAUNDICE / HEPATITIS	☐	☐	____	ALCOHOL
☐	☐	____	HERNIA				OZ. PER WEEK _____
☐	☐	____	URINE INFECTIONS (FREQUENT)	☐	☐	____	SMOKING
☐	☐	____	PAINFUL URINATION				CIG/DAY _____
☐	☐	____	BLOOD IN URINE	☐	☐	____	COFFEE / TEA
☐	☐	____	OVERNIGHT URINATION (2+)				CUPS PER DAY _____
☐	☐	____	CONTROL IN URINATION	☐	☐	____	CONTACT WITH BLOOD OR BODILY FLUIDS
☐	☐	____	DECREASE IN FORCE OF URINATION				☐ JOB ☐ VOLUNTEER
☐	☐	____	KIDNEY STONES				

FEMALES - PLEASE COMPLETE

☐	☐	____	PAIN / CRAMPS
☐	☐	____	PAIN / BLEEDING
☐	☐	____	AFTER SEX
☐	☐	____	FLUSHING / MENOPAUSE

DATE OF LAST:
PAP TEST _____
MAMMOGRAM _____
AGE OF ONSET _____
☐ REG.
☐ IRREG.
FLOW
☐ HEAVY
☐ MOD
☐ LIGHT

DAYS OF FLOW _____
LENGTH OF CYCLE _____
DATE OF1ST DAY OF LAST PERIOD _____
NUMBER OF PREGNANCIES _____
NUMBER OF LIVE BIRTHS _____
NUMBER OF MISCARRIAGES _____
BIRTH CONTROL METHOD _____
B.C. PILL (NAME) _____