BioHealth Wellness Center
Dr. David Siegel, DC CCN DACBN
659-i Park Meadow Rd, Westerville, Ohio 43081
614-423-7753 | staff@biohealthohio.com

Health History Questionnaire

Note: All information on this form will be kept strictly confidential. It is imperative that the information give is complete and accurate to properly assist you in your healing process.

Name: _____ Date of Birth _____/_____/_____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Phone: (C) _____ (H)

_____

Email: _____

Occupation: _____ Employer:

_____

Marital Status (please circle): Single Married Divorced Widow

Emergency Contact Name & Number: _____

Family Physician's Name: _____

Dentist's Name: _____

Main Health Concern(s)	**Date First Noticed**	**Severity (1-10)**
1.		
2.		
3.		
4.		
5.		

Any prior treatments for these symptoms? Y/N If so, by whom?

_____

What was the result of prior treatment? _____

_____

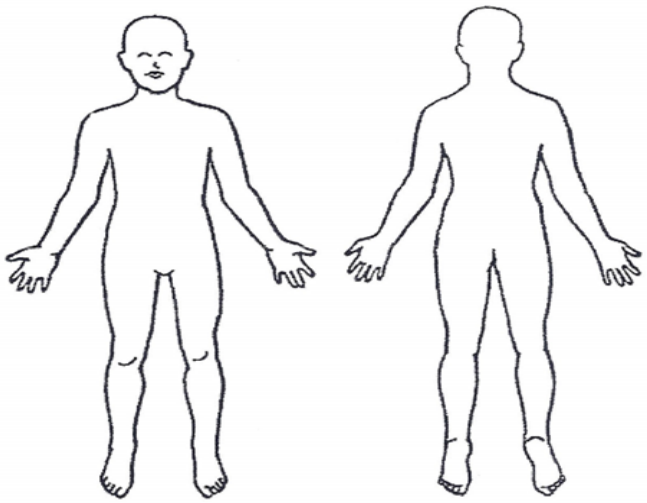
Have you had Bloodwork/X Rays/CT Scan or any other studies pertaining to your current condition(s) **done within the past year**? Y/N

What were the results? _____

_____

Indicate where your symptoms are occurring:

A= Aching | B = Burning | P = Pins/Needles | S = Stabbing Pain | T = Tightness | N = Numbness



Past Medical History

Surgeries, hospitalizations, and significant traumas (type & date): _____

_____

_____

Known allergies (drugs, chemicals, foods, etc.): _____

_____

Current medications including prescription and over the counter: _____

_____

Current vitamins, herbs, and nutritional supplements: _____

_____

How many courses of antibiotics have you had in the past 10 years? _____

How many Dental fillings (amalgams)? _____

Did your mother have amalgam fillings before your birth? Y/N

	YOUR OWN HISTORY	YOUR FAMILY'S HISTORY
Allergies		
Anemia		
Arthritis		
Autoimmune		
Cancer (please specify)		
Depression/Anxiety		
Diabetes		
Fibromyalgia		
Heart Disease		
Hepatitis A/B/C		
Hypertension		
Kidney Disease		
Obesity		
Osteoporosis		
Pacemaker		
Seizures		
Sinus Infections		
Substance		
Thyroid Disorder		
Other (please specify)		

Please describe any that apply, including use of medication, and family member(s) affected:

Energy and Exercise

Average energy level on a scale of 0 (extremely low) to 10 (Extremely high):

_____

What time of day is your energy: Highest? _____ Lowest?

_____

Do you fatigue easily? Yes/No

Do you exercise daily? Yes/No

Energy upon awakening: Poor/Good

Please describe frequency and type of exercise: _____

_____

Habits and Lifestyle

Please note any that apply to you, now or in the past, and indicate your usage per day or week. If none apply to you, leave blank.

	Per day/week	Age Started	Age Quit
Tobacco			
Alcohol			
Coffee			
Marijuana			
Cocaine			
Heroine			
Other (please specify)			

Dietary Preferences - Check all that apply

_____High protein/Low Carb
_____Spicy
_____Sweet
_____Sour
_____Artificial Sweeteners
_____Salty
_____Bitter
_____Cold drinks
_____Vegetarian
_____Fish/Seafood
_____Red meat
_____Eggs
_____Dairy
_____Raw foods diet
_____Low fat diet
_____Fast food

Stress

How many hours do you sleep per night? _____ Time you typically go to be_____
Time you typically get up in the AM? _____
Current Stress Level? (Best) 1 2 3 4 5 6 7 8 9 10 (Worst)
Reason for the stress level: Job ___ Health _____ Finances _____ Family _____ Other _____
I have difficulty with:

_____Falling asleep
_____Staying asleep
_____Grinding teeth
_____Disturbed sleep
_____Dreams
_____Nightmares
_____Waking up tired
_____Snoring
_____Feel unrested upon waking
_____Falling asleep without medications/supplements
_____Waking up around _____ am/pm and not able to fall asleep again

Muscles, Joints, and Bones

Check all that apply:
Swollen Joints___ Tendonitis___ Bone Pain___ Muscle Cramping___ Muscle Pain___ Repetitive Strain Injury___Other:
_____

WOMEN
_____ Hot Flashes
_____ Irregular Cycles
_____ Mood Swings
_____ Breast Tenderness
_____ Excessive bleeding and or clotting
_____ Low libido
_____ Cysts/Fibroids
_____ Fertility Issues

MEN
_____ Enlarged prostate, prostatitis
_____ Difficulty achieving/maintaining erections
_____ Lack of interest in sex
_____ Blood/mucus discharge
_____ Other reproductive issues (please list:) _____

Insulin Resistance	**VS.**	**Hypoglycemia**
_____Tired after eating/meals		_____Energy better after eating
_____Not hungry in AM		_____Hungry in AM
_____Craves sugar/carbs AFTER meals		_____Craves sugar BEFORE meals
_____Difficulty falling asleep		_____Difficulty staying asleep
_____Large buttocks (Women) Large belly (Men)		_____Large buttocks (Women) Large belly (Men)
_____Depression		_____Crashes &/or craves sweets in PM

Have you had any of the following done within the last 6 months? If so, record below.

HgbA1c (Value= _____)

Triglyceride (Value= _____)

Blood Sugar (Value= _____)

Total Cholesterol (Value= _____)

Any Thyroid Testing (Value= _____)

Dental and Other Toxicity Questions

Your exposure (in terms of hours per day) to the following:

TV _____ Computer _____ Cell Phone _____ Landline _____ Fluorescent Lights _____ Electric Blanket _____ WIFI _____

Do you live near any mobile phone tower, nuclear plant, polluting factor, high tension wires? Y/N

Have you received any Flu Vaccinations any time of in your life? Y/N When? _____

Have you ever have any negative reactions to any vaccinations? Y/N Explain: _____

_____

Have you ever had a negative reaction to any medications? Yes No

If so, which medication and what was the reaction? _____

_____

Have you ever been knocked unconscious? Y/N Have you ever been hit in the head? Y/N If so, details:

_____

_____

Please check all that apply

SYMPTOM	SOMETIMES	ALWAYS	SYMPTOM	SOMETIMES	ALWAYS
Spontaneous sweat			insomnia		
Nasal allergies			Tongue sores		
asthma			anxiety		
Shortness of breath			Feel warm all over		
cough			Frequent urination		
Dry nose/throat/skin			sore/cold/weak knees		
Low appetite			Low back pain		
Loose stools			Dizzy upon standing		
Gas/bloating after food			Feel better after exercise		
Sour belching			Floaters in vision		
Fatigue after food			Hot hands/feet		
Mouth sores			Afternoon fever		
Thirst			Night sweats		
Irritable			Flushed cheeks		
incontinence			Difficulty concentrating		
Tight feeling in chest			Ear ringing		
Feel worse with stress			Feel heart beating		

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Office Policies & Consents

Please initial each individual office policy on the line provided, and sign at the end.

_____ PAYMENT

I understand that payment is due at the time of service. Payment methods accepted: Cash, Check, Visa, MasterCard, Discover and American Express. Payment plans are available for programs and packages.

_____ INSURANCE & MEDICARE

I understand that no insurance is accepted, processed or billed by BioHealth Wellness Center. If I would like to submit my visit to insurance, BioHealth will gladly print a receipt for payment received and services rendered at that time that I may submit on my own. I understand all insurance matters are strictly between me and my insurance company and that BioHealth does not speak to insurance companies on my behalf. Therefore, BioHealth do not fill out any specific paperwork or respond to any mail sent to our office. Since the office does not accept Medicare, no receipts from BioHealth Wellness Center may be submitted to Medicare at any time for any reason.

_____ FINANCIAL RESPONSIBILITY & BILLING

I acknowledge all financial responsibility for myself (or guardian relationship) for services or products rendered under BioHealth Wellness Center.

_____ OUTSTANDING ACCOUNT BALANCE

I understand that there is any outstanding balance on my account remains for longer than 30 days, then I will be responsible for any expenses incurred in the collection of my account. Any accounts that become 45 days delinquent will be subject to a finance charge of 1.75% per month (21% APR). Any accounts that become more than 60 days delinquent will be referred for assignment to our collection agency. All additional charges equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added to the amount due.

_____ RETURNED CHECKS

I understand there is a $35 fee for returned checks for non-sufficient funds.

_____ CANCELLATIONS / NO CALL NO SHOWS

I understand that BioHealth Wellness Center tries to be flexible and accommodating regarding any needs to change an appointment, but cancellations without at least a 24-hour

notice and no-call/no-shows are subject to a $95 fee that must be paid before another appointment will be put on the schedule. For recurring instances, I may be required to pay in full prior to their visit. If the problem persists, patients could be terminated from the practice.

_____ LATE ARRIVALS

I understand that in order for Dr. Siegel and his staff to give his best care to all patients, they must allow enough time to complete the needed services and recommendations for each appointment. Therefore, they must adhere to the appointment times as scheduled. If I arrive more than 10 minutes late, my appointment will need to be rescheduled and is subject to a $95 fee. I understand they still have to adhere to our late policy regardless of traffic situations.

_____ SUPPLEMENT TESTING

I understand that within my regular Toxicology visit, Dr. Siegel will only advise on dosages of nutritional supplements that he has recommended. I understand that I cannot bring in supplements that I have got on my own or from another practitioner for Dr. Siegel to test during a Toxicology visit. I understand that if I wish to have any additional supplements tested, I must schedule a separate visit for that specific service to be performed and it will be at an additional cost.

_____ CELL PHONES

In order to protect the testing vials, I understand all cell phones must be completely POWERED OFF before entering Dr. Siegel's office. Airplane mode, silent and vibrate are not acceptable options in place of being powered off.

_____ VIALS

I understand that in an effort to keep my costs down, my treatment vials are re-used for each treatment and I must bring treatment vials to each appointment or there will be a $20 replacement charge for vials that are lost or forgotten.

_____ QUESTIONS REGARDING YOUR TREATMENT PLAN

I understand that during my scheduled appointments I am encouraged to ask questions about my treatments. However, if after my appointment I have questions or symptoms pertaining to my care at BioHealth Wellness Center, I can contact the office by an online portal via the website. If there is a need for longer discussions regarding new symptoms or questions, there will be a fee for additional time or Dr. Siegel may ask that you schedule a follow-up appointment. Dr. Siegel does not directly answer phone calls. Staff is fully trained to answer most of your questions. If I need to relay information to Dr. Siegel, I will complete the patient communication form found on the website. It is understood that BioHealth Wellness Center does their best to get an answer to patient's as quick as possible (within 48 hours), however, most the time questions are answered in between appointments.

_____ SPECIALTY LAB TESTING

I realize that any specialty lab tests are an out of pocket expense.

_____ HIPAA; NOTICE OF PRIVACY ACT

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. A major component of HIPAA addresses the privacy of individuals' health information by establishing information and how it can be used and disclosed. The document also states how protected health information may be disclosed to receiving payment/reimbursement through insurance. I certify that I have read and understand the HIPAA available to me from BioHealth Wellness Center.

_____ HOLD HARMLESS

I hold BioHealth Wellness Center/Dr. David Siegel, DC CCN DACBN harmless for any claims or damages in association of our work together.

_____ CONFIDENTIALITY STATEMENT

I understand that what I discuss with BioHealth Wellness Center/Dr. David Siegel, DC CCN DACBN will be treated confidentially in accordance with law and recognized professional standards.

_____ CANCER

I understand that Dr. Siegel does not diagnose or treat cancer, but his methods are effective for helping my immune system.

_____ DR. SIEGEL'S RECOMMENDATIONS

I understand that if I do not follow all of Dr. Siegel's recommendations that my results can take longer to achieve and that I must actively participate in my treatment at BioHealth Wellness Center such as making recommended lifestyle and or dietary changes.

_____ EMERGENCIES AND AFTER-HOURS CARE

In the event of a health emergency or urgent health problem, I realize I may need to contact 911 or go to the nearest hospital emergency room.

_____ PATIENT ACCEPTANCE

I understand that Dr. Siegel's methods of diagnosis and treatments are unique and that he does not accept every person into his programs.

_____ FORMS

I understand that Dr. Siegel does not write letters of disability or associated forms.

By signing below, I voluntarily consent and accept the above office policies, terms and conditions. I realize there are no guarantees given to me by BioHealth Wellness Center/Dr. David Siegel, DC CCN DACBN.

Signature: _____ Date: _____

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Privacy Notice

Is required by Federal Law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing our practice's legal duties and privacy practices with respect to your PHI.

Under the Privacy Rule, we may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

It is required to abide by the terms of this Privacy Notice.

We reserve the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

We will distribute any revised Privacy Notice to you prior to implementation.

We will not retaliate against you for filing a complaint.

Effective Date

This notice is in effect as of 5/1/2010.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice and my understanding and agreement to its terms.

Patient Signature (or patient's representative) *Date*

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Authorization for Release of Medical Records

Patient Information

Patient Name	DOB	Phone
Address	City/State	Zip

I authorize BioHealth Wellness Center to share my medical information with my family members or persons listed below:

FULL NAME	RELATIONSHIP

Exchange of medical information to family members or persons not listed on this authorization is strictly prohibited.

Consent

_____ I authorization BioHealth Wellness Center to share my medical information with family members or persons designated above.

_____ I authorize BioHealth Wellness Center to leave a message on my answering machine.

_____ I do not authorize BioHealth Wellness Center to share my medical information with any family members or other persons.

_____

Signature of patient, parent, guardian or representative *Date*

(*This consent is valid until revoked in writing by the signer)*

Informed Consent to Examination and Treatment

I hereby request and consent to the performances of examinations, homeopathic and nutritional treatments, adjustments/manual therapy and any other procedures and/or products, including, but not limited to, diagnostic tests, blood testing, salivary testing, diagnostic x-ray(s), physical therapy techniques, and/or neurological therapy techniques, on me, my child, or the person named below for which I am legally responsible for, which are recommended by Dr. David. A. Siegel, DC, DDN, DACBN of BioHealth Wellness Center.

I understand that, as with any healthcare procedure, there can be certain risks, however slight. I do not expect Dr. David Siegel, DC CCN DACBN to be able to anticipate all risks and complications. I wish to rely on them to exercise judgment during the course of the examination and/or treatment procedure(s), for which they feel are in my best interest.

1. I hereby authorize Dr. David Siegel, DC CCN DACBN / BioHealth Wellness Center to examine and treat my condition(s) as they deem appropriate, and I give authority for performance of the procedures Dr. Siegel recommends.
2. Dr. David Siegel, DC CCN DACBN / BioHealth Wellness Center will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.
3. I affirm that I am not currently pregnant or trying to become pregnant. Should this condition change, I will notify Dr. David A. Siegel and/or his staff as soon as possible.

Date of last Menstrual Period _____/_____/_____

____I have read or ____I have had it read to me the above statements regarding examination and treatment. By signing below, I state that I have weighed both benefits and risks and have decided that it is in my best interest to undergo the treatments recommended. I hereby give my consent for treatment. I understand results are not guaranteed.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

I understand the information above and guarantee all forms were completed correctly and to the best of my knowledge. I further understand it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient (or patient's representative and relation) Date