



Health History Questionnaire

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)
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1. _____

2. _____

3. _____

4. _____

5. _____

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

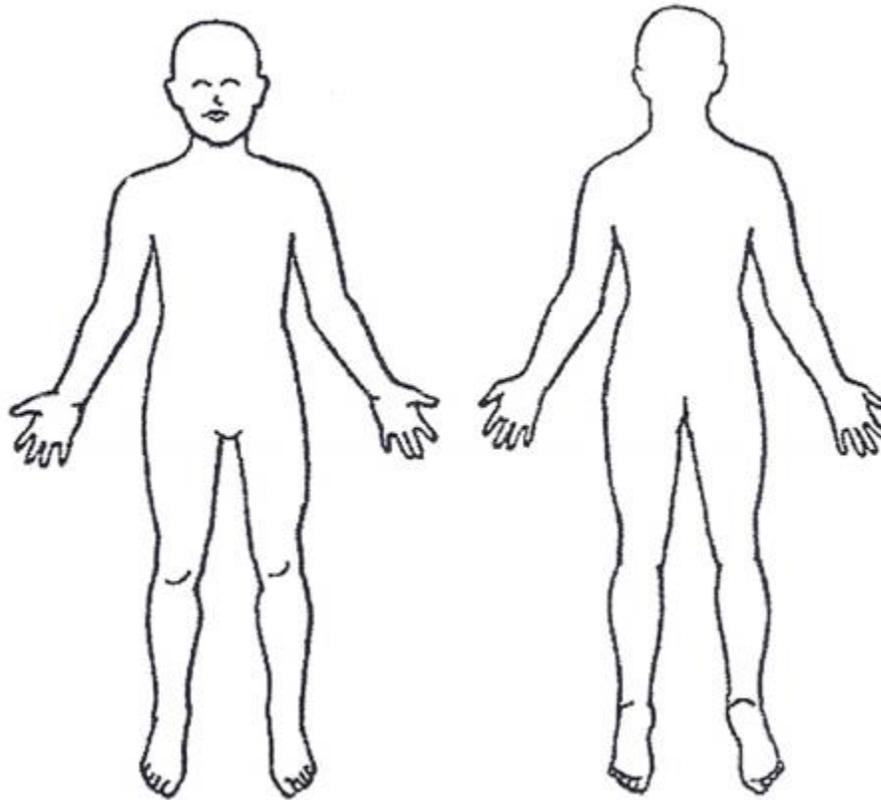
What was the result of prior treatment? _____

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			
Heroin			
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 bed _____

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
- ___ Not hungry in AM
- ___ Craves sugar/carbs AFTER meals
- ___ Difficulty falling asleep
- ___ Large buttocks (Women) Large belly (Men)
- ___ Depression

- ___ Energy better after eating
- ___ Hungry in AM
- ___ Craves sugar BEFORE meals
- ___ Difficulty staying asleep
- ___ Large buttocks (Women) Large belly (Men)
- ___ 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		

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 BioHealthOhio. If I would like to submit my visit to insurance, BioHealthOhio 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 BioHealthOhio does not speak to insurance companies on my behalf. Therefore, BioHealthOhio 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 BioHealthOhio 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 BioHealthOhio.

_____ 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 BioHealthOhio 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. A valid credit card may be required to schedule an appointment and any late or cancellation fees will be automatically charged to the card. 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 BioHealthOhio, 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 BioHealthOhio 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 BioHealthOhio.

_____ **HOLD HARMLESS**

I hold BioHealthOhio/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 BioHealthOhio/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 BioHealthOhio such as making recommended lifestyle and 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.

_____ **OUTSIDE LAB WORK (ORDERED BY ANOTHER DOCTOR)**

I understand that a separate consultation and fee applies for Dr. Siegel to review & consult on lab work that he did not order.

_____ **CREDIT CARD ON FILE**

I understand that a valid credit card is required to reserve an appointment and may be charged applicable fees if I cancel, no call no show or reschedule without 24 hour notice.

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 BioHealthOhio/Dr. David Siegel, DC CCN DACBN.

Signature: _____ Date: _____

Privacy Notice

It 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.

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Patient Signature (or patient's representative)

Date

Authorization for Release of Medical Records

Patient Information

Patient Name	DOB	Phone
Address	City/State	Zip

I authorize BioHealthOhio 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 authorize BioHealthOhio to share my medical information with family members or persons designated above.

_____ I authorize BioHealthOhio to leave a message on my answering machine.

_____ I do not authorize BioHealthOhio 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, CCN, DACBN of BioHealthOhio.

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 / BioHealthOhio 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 / BioHealthOhio 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 that 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