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.

DID YOU WATCH BOTH OF THE PRE-CONSULTATION VIDEOS? _____ **required prior to arrival or your appointment will be rescheduled.*

Name: _____ Date of Birth ____/____/____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Phone: (C) _____ (H) _____ (W) _____

Email: _____

Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Widow

Emergency Contact Name & Number: _____

Family Physician's Name: _____

Dentist's Name: _____

Main Health Concern(s)	**Date First Noticed**	Scale of 1-10 **Severity**
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/Xrays/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

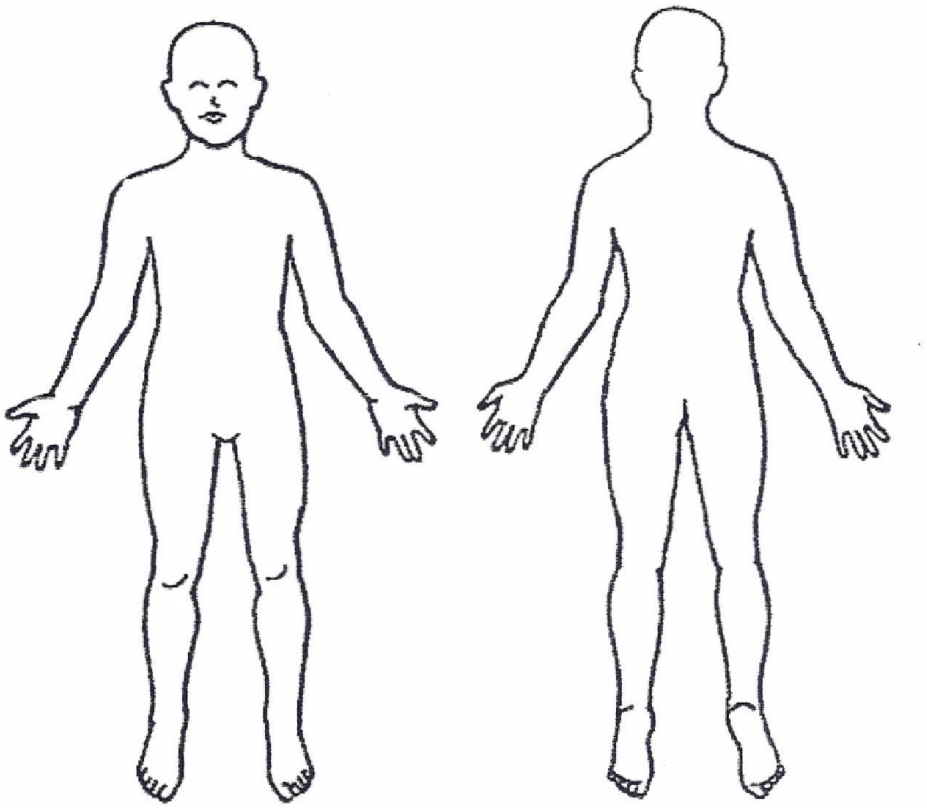
B = Burning

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		
Auto-Immune		
Cancer (please specify)		
Depression/Anxiety		
Diabetes		
Fibromyalgia		
Heart Disease		
Hepatitis A/B/C		
Hypertension		
Kidney Disease		
Obesity		
Osteoporosis		
Pace Maker		
Seizures		
Sinus Infection		
Substance Abuse		
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)

Vegetarian ____
Fish/Seafood ____
Red Meat ____
Eggs ____
Dairy ____
Raw Foods Diet ____
Low Fat Diet ____
Fast Food ____

High Protein/Low Carb ____
Spicy ____
Sweet ____
Sour ____
Artificial Sweeteners ____
Salty ____
Bitter ____
Cold Drinks ____

Hot Drinks ____
Warm Drinks ____
Extreme Thirst ____
Thirst w/ no desire to drink____
Processed Foods ____
Gluten Free ____
Soy Free ____

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 medication/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: _____

MEN

Enlarged Prostate, prostatitis ____
Difficulty achieving/maintaining erection ____
Lack of interest in sex ____
Blood/mucus discharge ____
Other reproductive Issues: _____
_____
_____

Women

Hot flashes ____ Low libido ____
Irregular cycles ____ Cysts/Fibroids ____
Mood swings ____ Fertility issues ____
Breast tenderness ____
Excessive bleeding &/or clotting ____

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 the results 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? _____

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			Fatigue		
Nasal Allergies			Catch colds easily		
Asthma			Feel worse after exercise		
Shortness of breath			General weakness		
Cough			Nasal discharge		
Dry nose/throat/skin			Sinus congestion		
Low appetite			Ravenous appetite		
Loss stools			Constipation		
Glas/bloating after food			Reflux/heartburn		
Sour belching			Nausea/vomiting		
Fatigue after food			Bruise easily		
Mouth sores			Gums bleeding		
Thirst			Organ prolapse		
Irritable			Muscle spasm		
Feel better after exercise			Numb extremities		
Tight feeling in the chest			Dry eyes		
Ear ringing			Anger easily		
Feel worse with stress			Red eyes		
Feel heart beating			Alternating diarrhea/constipation		
insomnia			Chest pain		
Tongue sores			Disturbing dreams		
Anxiety			Headaches		
Feel warm all over			Restlessness		
Sore/cold/weak knees			Feel cool all over		
Low back pain			Cold hands/feet		
Frequent urination			Edema/swelling		
Incontinence			Nighttime urination		
Dizzy upon standing			Early morning diarrhea		
Floaters in vision			Feel heavy		
Hot hands/feet			Sticky taste in mouth		
Afternoon fever			Foggy headed		
Night Sweats			Enlarged lymph nodes		
Flushed cheeks			Cloudy urine		
Difficulty concentrating					

AFFIDAVIT

Our primary goal is to get you better as fast as possible. To better secure your success, we find it extremely important that those closest to you be willing supporters of your healthcare decisions. Otherwise, negative attitudes and influences could possibly prevent you from receiving and/or responding to effective care that would otherwise benefit you.

To each and every patient, we dedicate ourselves to providing you with a listening ear and a caring heart. We offer a unique, alternative avenue of discovery and unrelenting efforts towards finding answers to your health struggles. True to our Mission, we will work to restore hope by finding the underlying causes to your health challenges and provide customized, natural and drug-free care to lead you on your path to optimal wellness.

To better assist yourself and others (ie: spouse, parent, relative, friend) as to what it is we do and as to what makes us different please review our website for more information (www.biohealthohio.com). It is imperative that you review these resources **PRIOR** to your initial appointment so that Dr. Siegel can make the best use of his and your time. If you should have any pertinent questions for Dr. Siegel, please write them down and bring them along.

This form must be signed and returned with your health forms before the doctor can examine you.

I, _____(signature) certify that:

• I understand that Dr. Siegel's methods of diagnosis and treatments are unique.

• I understand that Dr. Siegel does not accept every person into his treatment programs.

• I understand that I will do everything possible to bring my spouse, parent, relative, friend and/or significant other to the consult and case review with me.

• I understand that I must **actively** participate in my Health Recovery Treatment Program. I must try my very best to keep all scheduled appointments and make up any missed appointments as soon as possible.

• I understand that I most likely will be required to make lifestyle and/or dietary changes to which I must adhere to.

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

• I understand that Dr. Siegel does NOT accept nor process any insurance information/forms in his office.

Patient Signature Date

FINANCIAL POLICY

I understand the following:

- Payment is due in full at time of service or product order.
- All services rendered are charged directly to me, and I am ultimately responsible for the payment of my account.
- If I suspend or terminate my treatment, any fees for professional services rendered to me will become immediately due.
- Health and accident insurance are an arrangement between my insurance carrier and me.
- BioHealth does not communicate with insurance companies on my behalf.
- Upon request, BioHealth can provide a standard receipt for services as they are incurred, which I am completely and solely responsible for submitting to my insurance. BioHealth does not assist with any additional required insurance documentation.
- No receipt from BioHealth may be submitted to Medicare for any reason at any time.
- There is no refund on opened or used products.
- Returned checks are subject to a $30 returned check fee in addition to any other bank fees accrued by this office in the collection of funds.
- There is a $95 charge for any missed appointment with less than 24-hour cancellation notice, or for no call no shows. I may be required to pay the $95 fee in advance before being able to schedule a future appointment. After three occurrences, I will be required to pay for the full cost of my visit in advance.
- If 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.

Patient Signature Date

Patient's Representative (if minor or physically incapacitated) Relationship Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION (Please print):

Patient Name	DOB	SSN

Address	City/State	Zip	Phone

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

NAME	RELATIONSHIP

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

I give permission to leave a message on my answering machine. Yes No

CONSENT:

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

Signature of patient, parent, guardian, conservator or patient representative. (Please circle)	Date

Witnessed by:	Date

OR

NON-CONSENT:

I do not give my consent for BioHealth Wellness Center to share my medical information with any of my family members.

Signature of patient, parent, guardian, conservator or patient representative. (Please circle)	Date

Witnessed by:	Date

NOTE: 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 the doctors 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 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. BioHealth Wellness Center will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

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.

Patients Initials _____ 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 Date

_____
Signature of Patient's Representative (if minor of physically incapacitated / Relationship to Patient

Privacy Notice

The Practice:

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

Under the Privacy Rule, 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.

Is required to abide by the terms of this Privacy Notice.

Reserves 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.

Will distribute any revised Privacy Notice to you prior to implementation.

Will not retaliate against you for filing a complaint.

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

PATIENT ACKNOWLEDGEMENT
By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and agreement to its terms.

Patient Signature

Date

Signature of Patient's Representative (if minor of physically incapacitated / Relationship to Patient

3-Day Food Journal

Meal	Day 1:	Day 2:	Day 3:
Breakfast (First Meal)			
Snack			
Lunch (Second Meal)			
Snack			
Dinner (Third Meal)			
Snack			
Other			