



HISTORY OF CONDITION

PLEASE COMPLETE AND ANSWER ALL QUESTIONS AS CLEARLY AS POSSIBLE

IN YOUR WORDS,WHAT **PHYSICAL PROBLEMS** ARE YOU HAVING THAT BRING YOU TO THIS OFFICE?

1. _____
2. _____
3. _____
4. _____

HEIGHT:_____

WEIGHT:_____

BP:_____

LEFT OR RIGHT

CURRENT **MEDICATIONS**:_____

CURRENT **ALLERGIES**:_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS:

<input type="checkbox"/> DIABETES	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> MUMPS
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> MENTAL DISORDER	<input type="checkbox"/> MEASLES
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HERPES	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> CHICKEN POX
<input type="checkbox"/> CANCER	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> VASCULAR DISEASE	<input type="checkbox"/> POLIO

LIST ANY **SURGERY** YOU HAVE HAD OF ANY KIND?_____

DO YOU HAVE A HISTORY OF **HOSPITALIZATIONS**?_____

HAVE YOU HAD ANY **PREVIOUS INJURIES/ACCIDENTS**? DATES?_____

- ◆ DO YOU **SMOKE**? **Y/N** HOW MUCH?_____PACKS/DAY
- ◆ DO YOU DRINK **ALCOHOL**? **Y/N** HOW MUCH?_____DRINKS/DAY
- ◆ HOW MUCH **CAFFEINE** DO YOU CONSUME A DAY? _____DRINKS/DAY

DOES YOUR FAMILY HAVE A HISTORY OF ANY CHRONIC ILLNESS?

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

HEENT	CARDIORESPIRATORY	GASTROINTESTINAL	GENTOURINARY	NEUROPSYCH
<input type="checkbox"/> HAIR LOSS/SCALP PAIN	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> ABDOMEN PAIN	<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> DIZZINESS
<input type="checkbox"/> DIFFICULTY W/ VISION	<input type="checkbox"/> LEFT ARM PAIN	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HESITANCY	<input type="checkbox"/> CONFUSION
<input type="checkbox"/> DOUBLE VISION	<input type="checkbox"/> PALPATIONS	<input type="checkbox"/> BLOATING	<input type="checkbox"/> FREQUENCY	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> DIFFICULTY HEARING	<input type="checkbox"/> COUGHING	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> BLADDER	<input type="checkbox"/> FATIGUE
<input type="checkbox"/> RINGING OF EARS	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> GERD	CONTROL	<input type="checkbox"/> NUMBNESS
<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> SHORT BREATH	<input type="checkbox"/> PENCIL STOOL	<input type="checkbox"/> PAIN	<input type="checkbox"/> TINGLING
<input type="checkbox"/> NASAL DISCHARGE	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> LIVER PROBLEM	URINATION	<input type="checkbox"/> SWEATS
<input type="checkbox"/> DIFFICULTY CHEWING	<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> LOSS OF WEIGHT		<input type="checkbox"/> FEVER
<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/>	<input type="checkbox"/> CRAMPS		<input type="checkbox"/> MEMORY LOSS
<input type="checkbox"/>		<input type="checkbox"/> RASHES SKIN		
<input type="checkbox"/>				

NAME:_____ SIGNATURE:_____ DATE:___/___/___

SYMPTOM SURVEY

- 12) **General Symptoms** (circle as many as apply)
 A) Nervousness B) Irritability C) Fatigue
 D) Depression E) Loss of Sleep F) Tension
 G) PMS

- 13) **HEAD** (circle as many as apply)
 A) Headache 1. Mild, 2. Moderate, 3. Severe
 Scale of 1-10: _____
 How Often (1-2-3-4-5-6) per _____
 1. Constant, 2. Intermittent, 3. Throbbing

Located: 1) Back of head; 2) Forehead
 3) Temples; 4) Right side
 5) Left side 6) Behind eyes

- B) Lightheaded C) Memory Loss D) Fainting
 E) Blurred vision F) Double Vision
 G) Sensitivity to light H) Loss of Balance
 I) Hearing Loss J) Ringing in ears

- 14) **NECK:** (Circle as many as apply)
 A) Pain - 1. Left side, 2. Right side, 3. Both
 Level - 1. Mild, 2. Moderate, 3. Severe
 On a scale of 1-10 _____

- 15) **SHOULDERS** (Circle as many as apply)
 A) Pain in joint 1. Left 2. Right 3. Both
 B) Pain across shoulder 1. Left 2. Right 3. Both
 C) Limitation of Movement 1. Left 2. Right 3. Both
 D) Tension 1. Left 2. Right 3. Both

- 16) **ARMS** (Circle as many as apply)
 A) Pain in upper elbow 1. Left 2. Right 3. Both
 B) Pain in elbow 1. Left 2. Right 3. Both
 C) Pain in forearm 1. Left 2. Right 3. Both
 D) Pins & Needles (Arm) 1. Left 2. Right 3. Both
 E) Pins & Needles (forearm) 1. Left 2. Right 3. Both
 F) Numbness in arm 1. Left 2. Right 3. Both
 G) Numbness in forearm 1. Left 2. Right 3. Both

- 17) **HANDS** (circle as many as apply)
 A) Pain in wrist 1. Left 2. Right 3. Both
 B) Pain in hand 1. Left 2. Right 3. Both
 C) Pins & Needles, hand 1. Left 2. Right 3. Both
 D) Numbness, hand 1. Left 2. Right 3. Both

- 18) **MID BACK** (Circle as many as apply)
 A) Pain 1. Left 2. Right 3. Both
 Level: (scale of 1-10) _____
 Type: 1> Sharp/stabbing 2> Dull ache
 B) Muscle Spasm 1. Left 2. Right 3. Both

- 19) **CHEST**
 A) Deep Chest pain 1. Left 2. Right 3. Both
 Pain Level 1. Mild 2. Moderate 3. Severe
 B) Pain around ribs 1. Left 2. Right 3. Both
 C) Shortness of breath
 D) Irregular heartbeat

- 20) **ABDOMINAL SYMPTOMS**
 A) Pain 1. Mild 2. Moderate 3. Severe
 B) Nervous Stomach C) Nausea D) Gas
 E) Constipation F) Diarrhea G) Heartburn
 H) Indigestion I) Loss of Appetite

- 21) **LOW BACK PAIN**
 A) Upper lumbar pain 1. Left 2. Right 3. Both
 B) Lower lumbar pain 1. Left 2. Right 3. Both
 C) Sacroiliac pain 1. Left 2. Right 3. Both
 D) Muscle Spasm 1. Left 2. Right 3. Both

Pain level: 1. Mild 2. Moderate 3. Severe
 Scale of 1-10 _____

- 22) **HIPS AND LEGS**
 A) Pain in buttocks 1. Left 2. Right 3. Both
 1. Mild 2. Moderate 3. Severe
 B) Pain in Hip joint 1. Left 2. Right 3. Both
 1. Mild 2. Moderate 3. Severe
 C) Pain down leg 1. Left 2. Right 3. Both
 Location 1. Front 2. Back 3. Side
 Radiates to: 1. Knee 2. Calf 3. Foot
 D) Numbness down leg 1. Left 2. Right 3. Both
 Location: 1. Front 2. Back 3. Side
 E) Pins and needles 1. Left 2. Right 3. Both
 Location: 1. Front 2. Back 3. Side
 F) Knee pain 1. Left 2. Right 3. Both
 G) Leg cramps 1. Left 2. Right 3. Both

- 23) **FEET**
 A) Ankle Pain 1. Left 2. Right 3. Both
 B) Swollen ankles 1. Left 2. Right 3. Both
 C) Foot pain 1. Left 2. Right 3. Both
 D) Numbness/feet 1. Left 2. Right 3. Both

OTHER SYMPTOMS THAT YOU HAVE: _____

ARE ALL OF THESE SYMPTOMS DIRECTLY CAUSED BY THE ACCIDENT: YES NO

 PATIENT SIGNATURE



ASSIGNMENT OF BENEFITS

RECORDS RELEASE, ASSIGNMENT OF BENEFITS, RESERVATION OF BENEFITS, REQUEST TO ESCROW DISPUTED BENEFITS RELATED TO PROVIDOR'S CLAIM, DURABLE POWER OF ATTORNEY TO NEGOTIATE INSURANCE PAYMENTS, LIEN ON PROCEEDS OR SERVICES RENDERED AND GENERAL PATIENT RESPONSIBILITIES. INFORMED CONSENT OF TREATMENT AND PRIVACY PRACTICES

For the consideration of receiving services by *SEABREEZE MEDICAL NETWORK, INC.*, I hereby agree to the following:

RECORDS RELEASE: I authorize assignees to release any information pertaining to my case/condition to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS. Pursuant to Florida Statutes 627.736(5). I hereby assign my insurance benefits under my automobile and/or group insurance to *SEABREEZE MEDICAL NETWORK, INC.*, the assignees. In this event my insurance company obligated to make payments to me upon charges made by assignees for services, refuse to make or reduces such payments and in order to maximize the benefits available under policy coverage, hereby request the insurance company (Assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignees the full amount of the bills submitted), to avoid exhaustion of coverage while Assignees pursues its rights under this Assignment to the parties of this agreement (the assignees and I) further authorize, direct, notice and request the insurance Company to set aside and place in escrow an amount equal to the full amount any such denials and reduction, and to hold that amount in escrow until the dispute is resolved legally.

DURABLE POWER OF ATTORNEY TO NEGOTIATE INSURANCE PAYMENTS: I hereby grant *SEABREEZE MEDICAL NETWORK, INC.*, power of attorney to endorse checks and/or sign any piece of paper which will enhance or expedite payment to assignees for services rendered, including but not limited to a release of medical records and assignment of benefits/authorization to pay.. Know by all these present that: The undersigned as made, constituted and appointed, and by these presents does hereby make, constitute and appoint *SEABREEZE MEDICAL NETWORK, INC* and any of its duly authorized agents and employees as and to be the undersigned true and lawful attorney for and in the undersigned's name, place and instead to endorse any and all checks, drafts or monies orders which are made payable to the undersigned alone or to the undersigned and *SEABREEZE MEDICAL NETWORK, INC* which checks which checks, drafts or money orders are made payable for services which have been made by *SEABREEZE MEDICAL NETWORK, INC* at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order. Furthermore, the undersigned allows *SEABREEZE MEDICAL NETWORK, INC* and any of its agents to sign any papers that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements. The undersigned by these resents does give and grant *SEABREEZE MEDICAL NETWORK, INC* as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and proposes as the undersigned might or could do, to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document. Hence, I agree that the above mentioned/Assignees be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms or payments of my bill, if any insurance draft arrives at the assignee's office drawn in my name or both names for payment of services rendered and submitted to the carrier. This durable power of attorney is not affected by subsequent incapacity and the principal except as in 709.08, Florida statutes.

LIEN ON PROCEEDS FOR SERVICES RENDERED: I authorize you, my insurance company and/or my attorney, to pay directly to *SEABREEZE MEDICAL NETWORK, INC*, ("Assignees") all such sums as may be due and owing to the Assignees for services rendered, and to withhold such sums for any disability benefits, medical payments, No-Fault benefits, or any other insurance benefits obligated to reimburse me for any claims, settlement, judgment, or verdict for me, as may be necessary to adequately protect said Assignees for payment of services rendered. I give this lien to said Assignees for any and all insurance benefits and any and all proceeds of any settlement, judgment, verdict or other monies which may be paid to me as a result of the injuries or illness for which I received services by Assignees, to the extent they have provided services and remain unpaid for services provided.



ASSIGNMENT OF BENEFITS cont.

GENERAL PATIENT RESPONSIBILITIES: I understand that I remain personally responsible for the total amount due Assignees for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have insurance deductibles or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignees to await payments and they may demand payments from me immediately upon rendering services, although the assignees agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collections and/or suit, the assignees shall be entitled to reasonable fees for collection. I also understand that if any bad check is written, I agree to pay for those added costs.

INFORMED CONSENT OF TREATMENT: I understand that spinal manipulation has health risk associated, ie CVA, cauda equina syndrome, rib sprains/strains, nerve root irritation, and spinal cord compression.

PRIVACY PRACTICES: I acknowledge that i was provided a copy of the **NOTICE OF PRIVACY PRACTICES** and that I have read them or declined the opportunity to read them and understand the **NOTICE OF PRIVACY PRACTICES**. I understand that this form will be placed in my patient chart and maintained for six years.

Dated this _____ day of _____ 20__

Patients Signature

Witness

Patients Name Printed

SEABREEZE MEDICAL NETWORK, INC