FIT FOR LIFE HEALTH SERVICES, P.A.

2960 IMMOKALEE RD SUITE 1 & 2 NAPLES FL 34110
PHONE (239) 513-9800 FAX (239) 513-0043

SUZANNE SEEKINS, D.C.,C.C. CHRIS OURGANIAN, D.C. LINDSAY S.T. DODD, D.C.
LINDSAY ORTH, D.C. ABIGAIL SMITH, D.C.

Today's Date: _____/ _____/ _____

WOMEN ONLY

CONFIDENTIAL PATIENT CASE HISTORY

Please fill out ALL forms to the best of your ability. If something doesn't apply, please write N/A.
Sign ALL area's for signature. If you have questions please ask front desk.

Personal Information

Name_____Nickname_____Social Security#_____

Address_____City_____State_____Zip_____

Northern Address (if applicable)_____City_____ State_____Zip_____

Home Phone #(_____)_____ Age_____ Date of Birth_____/_____/_____

Marital Status: S M D W

Employer_____ Occupation/Previous Occupation _____

Work Phone #(_____)_____ Cell Phone (_____)_____ Carrier_____

Emergency Contact Name and Phone #_____

E-mail Address_____

Please fill in: Who referred you to our office? _____

Health Information

Worker's Comp. Accident? Yes ___ No ___ Recent Auto Accident? Yes ___ No ___ (Please notify front desk if answered yes)
Date of Last menstrual period _____/_____/_____ What trimester are you in? _____
What is your major complaint? _____
How and when did it start?
_____
_____
Any Treatment for this condition recently or in the past? No ___ Yes___ If Yes, What kind? _____
Past Chiropractic Care? _____ **Home Treatments:** _____

Radiation of Pain? Leg ____ Knee ____ Foot ____ Shoulder ____ Arm ____ Other_____
Other Symptoms: Burning ____ Tingling ____ Numbness ____ Shooting ____ Dizziness/Vertigo _____

Pain Worse w/: Sitting ___ Standing ___Rising from chair ___ Lying Down ___Walking ___ Driving __ Bending__ Lifting __Resting_
Pain Interfering w/: Work ____ Sleep ____ Daily Routines ____ Exercising ____ Golfing ____ Other _____
Pain better w/: Sitting __Standing __Lying Down ___Walking ___Movements ___Rest __Activity __ Medications __ Heat __ Ice ___
Pain: ↑/↓ Morning ↑/↓ Evening ↑/↓ Sleeping ↑/↓ Weather ↑/↓ Stretching/Exercising _____

Are you suffering from: Lower Back Pain ____Neck Pain ____ Shoulder Pain ____ Wrist Pain ____ Elbow Pain ____ Foot Pain____
Knee Pain____ Headaches ____ Asthma ____ Neuritis ____ Digestive Disorders ____ Nervousness ____ Sinus Trouble ____
Hand Pain ____ Heart Condition ____ Diabetes ____ Other? _____

Before Pregnancy

Height _____**Wt.** _____ **Exercise:** Regularly __ Frequently __ Occasionally __ **Alcohol**: Socially __Seldom __ **Smoking:** Yes/No

High Blood Pressure Yes No Diabetes Yes No Is this your first pregnancy Yes No, if no:
How many children do you have? _____ **How far apart is each child?** _____
What was your delivery method? Natural C-section-Planned C-section-Emergency Drug-induced Whirlpool
Other: _____

Did you need any medication during these pregnancies, including antibiotics? Yes No, if yes:
What are the names of the medications, I.V. treatments, etc?

_____

Were there any complications with any of the previous pregnancies? Yes No, if yes, explain: _____

_____

_____

During Pregnancy

Height _____Wt. _____ Exercise: Regularly __ Frequently __ Occasionally __ **Alcohol**: Socially __Seldom __ **Smoking:** Yes/No
What type of sleeper are you? Back_____ Stomach _____ Left Side _____ Right Side_____
Do you use a pillow or cushion between your legs when you sleep? Yes No Sometimes
High Blood Pressure Yes No Gestational Diabetes Yes No
What is your delivery method? C-Section Yes No Vaginal Delivery Yes No Whirlpool Yes No
Other: _____

Do you have an OBGYN? Yes No Are you currently seeing them? Yes No Please provide the OB's name and contact information (name and number): _____

Medication Taking (prescribed and over-the-counter): _____

_____

_____

Other Medical Condition(s) Currently Being Treated For: _____
Allergy and Type: Medication, Food, Environment (write M, F, E next to allergy)
When and what was adverse reaction?

_____

_____

List Surgical Operations and When: _____

_____

_____

Primary Care Physician? Yes ___ No ___ Name of Physician: _____
Last Physical: _____ **Most Recent Bone Density Test:** _____
List physicians seen within the last year and for what condition(s) _____

_____

Hospitalization:
Dates (approx.) _____
Reason: _____

_____

Hospital name: _____
Diagnostic Tests: Please circle
Type: Angiography, Cardiac Echo, Chemistry, CT, MRI, Nuclear Medicine, Pathology, Ultrasound, X-ray,
Other: _____ **Dates (approx.)** _____
Test (i.e. CT chest) _____
Results: _____
Abnormal: _____
Family History: Please list any health issues experienced by your family members
Relationship: Mother, Father, Brother #___ Sister #___
History: Heart disease, High blood pressure, Kidney disease, Stroke, Thyroid, Parkinson's disease (PD), Multiple Sclerosis (MS), Alzheimer's disease, Autoimmune disease, Diabetes, Cancer
Mother:

_____

_____

Father:

_____

_____

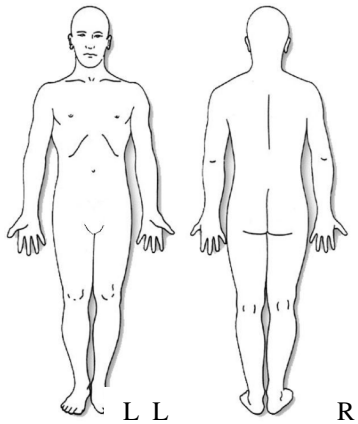
Sibling: (brother or sister)

_____

Deceased: whom: _____ **Cause of Death:** _____
Occupational History: List all current and or past jobs that may have physically or chemically affected your health
Retired: Yes No
Start date approx. _____**End date approx.** _____
Occupation: _____ **Status:**_____
Any known risk factors with occupational jobs? Chemical exposure, dust, asbestos exposure, smoke, etc.

_____

Mark the areas on the picture where you feel the below sensations. Use the appropriate symbol to mark all affected areas.



Numbness	Burning	Stabbing	Pins&Needles
- - -	x x x	/ / /	o o o

Financial Agreement

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

Our practice is acutely aware of the escalating healthcare costs and we are doing everything feasible to help lower them through increased efficiency. Recent changes in health benefits have resulted in larger patient co-pays, deductibles and coinsurance. It is costly and inefficient to send patients a bill/statement or to call the Insurance Company to verify your coverage. Our staff is happy to assist you in determining if you are in or out of network, and will try to assist you in estimating what portion of our fees is your responsibility; however this will NOT be a guarantee of coverage, and or payment. Due to the high volume in our office we might ask you to please verify your chiropractic coverage.

Because insurance companies commonly misquote benefits and deductible status, we request that you assist us in helping to reduce billing costs by completing the credit/debit card authorization below. By signing the authorization, you can be assured that your credit card will be charged only for those fees that your insurance company has determined that you owe. We honor all contractual obligations with insurance companies with which we participate, so you will never be charged for any amounts in excess of those that are allowed. You will be contacted via phone to be informed of the amount that will be charged to your credit card. The amount charged to your credit card will equal the amount shown on your EOB (Explanation of Benefits). If account has balance due to office for **which I am legally responsible, including co-pays, deductibles, coinsurance, non-covered charges, supplements, supplies, or missed payment at the time of appointment** the credit card will be charged. If unavailable, a message may be left and if unable to leave a message, credit card will still be charged.

Please note at ALL visits there will be a fee collected; whether it be, deductible, co-pay or coinsurance for the services rendered at the time of service. If for some reason we have collected a larger amount than needed, your account will be credited accordingly

Patient Name_____ **Card Holder** _____

Credit/Debit Card # _____-_____-_____-_____ **CVV #** _____ **Zip**_____

Expiration (MM/YY) _____/_____ **Address #**_____

MC Visa Disc Amex

I CLEARLY UNDERSTAND THE FINANCIAL AGREEMENT AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO MY INSURANCE AND OR DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE FFLHS TO CHARGE MY CC. **I hereby agree that if this office is required to institute a legal action to collect any past due balance upon my account, I shall be responsible for attorney's fees and costs of suit incurred by this office for said legal action**.

_____ _____

Signature of patient Date

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REVIEW OF SYSTEMS

Please check any symptoms you have been experiencing in the last 6 months!

General

☐ Fatigue ☐ Weight Gain ☐ Difficulty Losing Weight ☐ Insomnia
☐ Sleep Disturbance ☐ Brittle Nails ☐ Thickened Heel Pads ☐ Thinning Skin
☐ Hair Loss ☐ Increased Facial or Body Hair ☐ Water Retention ☐ Decreased Stamina

Notes: _____

CNS

☐ Recent Headaches ☐ Foggy Thinking ☐ Memory Lapses ☐ Decreased Mental Sharpness
☐ Unusual Sweating ☐ Tremors

Notes: _____

EENT

☐ Hearing Loss ☐ Ringing in the Ears ☐ Dizziness ☐ Light Headed
☐ Post Nasal Draining ☐ Recurrent Sinus ☐ Allergies ☐ Chemical Sensitivity

Notes: _____

CV / RES

☐ Shortness of Breath ☐ Persistent Cough ☐ Bronchitis ☐ Chest Pain
☐ Palpitation ☐ Asthma ☐ High Blood Pressure ☐ Low Blood Pressure

Notes: _____

GI

☐ Loss of Appetite ☐ Sugar Cravings ☐ Increased Appetite ☐ Indigestion
☐ Reflux ☐ Gas ☐ Constipation ☐ Diarrhea

Notes: _____

GU

☐ Incontinence ☐ Increased Urinary Frequency ☐ Painful Urination
☐ Decreased Urine Flow ☐ Prostate Problems ☐ Erectile Dysfunction

Notes: _____

Endocrine

☐ Hx of Thyroid Dz ☐ Hx of Diabetes ☐ Hypoglycemia ☐ Breast Tenderness
☐ Cystic Ovaries ☐ Heavy Menses ☐ Infertility ☐ Missed Periods
☐ Night Sweats ☐ Vaginal Dryness ☐ Hot Flashes ☐ Decreased Libido

Notes: _____

Vascular

☐ Coldness in Hands or Feet ☐ Numbness in Hands or Feet

Notes: _____

NMS

☐ Joint Pain ☐ Arthritis ☐ Gout ☐ Aches / Pains

Notes: _____

Psychiatric

☐ Irritable ☐ Anxious ☐ Nervous / Stressed ☐ Burned Out
☐ Apathy ☐ Tearful ☐ Depressed

Notes: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score_____

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTAION

1. I, _____, hereby authorize **Fit For Life Health Services, P.A.**
   (Name)
   to use and /or disclose to my insurance company for the following specific protected health information.: Progress notes, X-Ray notes, and any other requested correspondence.
2. I understand that this authorization is valid until patients' treatment is completed.
3. I understand that the purpose or use of the disclosure I am granting: Thank you cards, phone calls, recalls, statements, and anything else necessary for your care.
4. I expressly acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:
   _____
   _____
6. I understand that this authorization maybe revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have effect on disclosures occurring prior to the execution of nay revocation.
7. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
8. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form
9. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
10. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
11. This authorization is valid as of _____/_____/_____, the date I have signed below.

_____ _____
Patient Name (Printed) Patient or Legal Guardian Signature

HIPAA Notice of Privacy Practice for Fit For Life Health Services, P.A.

Protecting the privacy of your Personal Health Information ("PHI") is important to us. Our Notice of Privacy details how information about you may be used and disclosed and how you can get access to that information.

By checking the lines below I authorize being contacted for practice reminders by:

Mail _____;
Email_____; at email address _____;
Telephone numbers; including Text and or Voicemail: _____
(put phone # if different from personal information section) _____;

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

_____

By signing the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. I acknowledge that I was offered 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.

_____ _____
Patient Name (please print) Date

_____
If applicable - Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

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AUTHORIZATIONS & RELEASES

Consent for Treatment

Chiropractic care; like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. (As a comparison, another interesting fact: 1.2 percent of patients taking one NSAIDS (example: Aspirin, Motrin, Ibuprofen) daily are hospitalized for upper GI problems per year. That is over one in one hundred! Plus, taking one aspirin per day for three years increases the risk of developing cancer by eighty percent!) Prior to receiving care at this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I the undersigned, hereby authorize, **(please check which one you are appointed with)** ☐ Dr. Suzanne Seekins ☐ Dr. Lindsay Dodd ☐ Dr. Chris Ourganian ☐ Dr. Lindsay Orth ☐ Dr. Abigail Smith and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests and administer treatment necessary.

Signature: X_____Date:_____

Authorization to Release Medical Information

I authorize the release of my medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this office is correct and complete. **Initial: X**_____

Request for Payment of Benefits to Provider of Care

I hereby authorize my Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to FIT FOR LIFE HEALTH SERVICES, P.A., and the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given any power of attorney to endorse/sign my name on any and all draft for payment of my bill.

I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account

_____ _____ _____

Patient Signature Date Witness

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AUTHORIZATIONS & RELEASES

Assignment of Benefits & ERISA

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature:_____ Date:_____

Print Name:_____