SEACREST
Health & Wellness Center

Dr. Will Rogers, DC, DACNB
Dr. Dean Peppard, DC
www.SeacrestHWC.com

714-821-4265
www.SeacrestHWC.com

PATIENT INFORMATION

Name:_____ ☐M ☐F

Date of Birth:____/____/_____ Age:____ __

SSN: _____ - ____ - _____ (full number for PI/WC)

Driver's License:_____ State:_____

Cell Phone: (_____)_____

Home Phone: (_____)_____

Email:_____

Street Address:_____

City:_____, State____ Zip:_____

Marital Status: _____

Emergency Contact:_____

Emergency Phone:_____

How did you hear about us?

_____

EMPLOYMENT INFORMATION

Occupation:_____

Employer:_____

Phone:_____

Address_____ Suite:____

City:_____, State____ Zip:_____

INSURANCE INFORMATION

Please check one/any of the following:

☐ I have *Medicare Part B*. Please hand your **Medicare card** and **driver's license** to the front desk.

☐ I would like to bill my *insurance*. Please provide us with your **insurance card and driver's license.**

☐ I am seeking help due to an injury from a car accident.

☐ I am seeking help due to an accident in my workplace.

☐ I wish *not* to bill any insurance company. (We still need your **driver's license**)

For Staff Use Only

Patient #:_____ **Type:** Insurance / PI / Medicare/Self-Pay Date:_____

☐ New ☐ Updated ☐ DL ☐ Insurance Card ☐ NP Letter ☐ Referral TY

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_____ _____
Patient Name Date

CHIEF COMPLAINT(S)

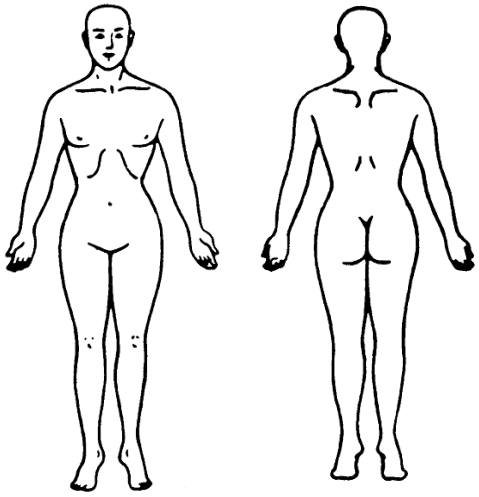
Please describe the problem(s) in your own words and place in order of priority with most important first:

_____

_____

_____

If symptoms are pain related, please indicate the approximate location(s) of the pain:



Please circle a # 0-10, 0 being no pain, 10 being worst possible pain)

My pain is *generally*: **[0 1 2 3 4 5 6 7 8 9 10]**

My pain *right now*: **[0 1 2 3 4 5 6 7 8 9 10]**

Pain quality (please check any that apply):

☐ **Sharp/Stabbing** ☐ **Dull/Achy**

☐ **Tingling** ☐ **Numbness**

☐ **Burning** ☐ **Stiffness**

When did symptoms begin? ___/___/_____ Sudden Onset or Gradual?:_____

Since onset, symptoms have gotten: ☐ **Better** ☐ **Worse** ☐ **Same** Symptom Frequency: ☐ **Constant** ☐ **Intermittent**

Do you know what caused the problem(s)?: ☐ **Y** ☐ **N** If yes, explain:

_____

Does anything *relieve* symptoms? ☐ **Y** ☐ **N** If yes, explain: _____

_____

Does anything *aggravate* symptoms? ☐ **Y** ☐ **N** If yes, explain: _____

_____

Has this problem affected normal sleeping pattern? ☐ **Y** ☐ **N** If yes, explain: _____

_____

How does this problem affect…

Home Life: _____

Work/School Life: _____

What is your ultimate goal for treatment? (e.g. “Play golf again” or “Hold my grandchild”):

_____

_____

What is your commitment level to achieving this goal (rate #1-10, 10 being most commited): _____

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Patient Name _____ Date _____

SYMPTOMS CHECKLIST

Please check if appropriate.

Orthopedic & Musculoskeletal

□ "Clunk" Sounds	□ Shoulder Pain	→	□ **Left** □ **Right**
□ Neck Pain	□ Upper Arm Pain	→	□ **Left** □ **Right**
□ Upper Back Pain	□ Elbow Pain	→	□ **Left** □ **Right**
□ Lower Back Pain	□ Forearm Pain	→	□ **Left** □ **Right**
□ Jaw Pain	□ Wrist Pain	→	□ **Left** □ **Right**
□ Clicking in Jaw	□ Hand Pain	→	□ **Left** □ **Right**
□ Face Pain	□ Hip Pain	→	□ **Left** □ **Right**
□ Chest Pain	□ Upper Leg Pain	→	□ **Left** □ **Right**
□ Stomach Pain	□ Knee Pain	→	□ **Left** □ **Right**
□ Range of Motion Problems	□ Lower Leg Pain	→	□ **Left** □ **Right**
□ Radiating Pain	□ Ankle Pain	→	□ **Left** □ **Right**
□ Muscle Spasms	□ Foot Pain	→	□ **Left** □ **Right**
□ Bruise/Contusion to: _____	□ Numb/Tingling Arm/Hand	→	□ **Left** □ **Right**
□ Abrasion/Scrape to: _____	□ Numb/Tingling Leg/Foot	→	□ **Left** □ **Right**
□ Other: _____	□ Weakness Arm/Hand	→	□ **Left** □ **Right**
□ Other: _____	□ Weakness Leg/Foot	→	□ **Left** □ **Right**

Neurological

□ Memory Problems	□ Attention Problems	□ Dizziness/Vertigo
□ Stress/ Anxiety	□ Learning Disabilities	□ Headaches/ Migraines
□ Head Trauma	□ Speech Problems	□ Movement Problems
□ Balance/Walking Issues	□ Brain Fog	□ Hyperactivity
□ Depression/Sadness	□ Abnormal Fatigue	□ Confusion/ Disorientation
□ Frustration/ Irritability	□ Reading/Writing Problems	□ Panic Attacks
□ Visual Disturbances	□ Sleep Disruption	□ Anti-Social Tendencies
□ Nausea/Vomiting	□ Mood Swings	□ Appetite Change
□ Pupils Different Sizes	□ Personality Change	□ Difficulty Making Decisions
□ Change in Sexual Function	□ Reduced Confidence	□ Feeling of Helplessness
□ Apathy (Don't Care)	□ Hearing Problems	□ Impatience

□ Other: _____

□ Other: _____

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Patient Name _____ Date _____

HEALTH HISTORY

Allergies	☐Past	☐Present	Rheumatic Fvr	☐Past	☐Present	**Height:** _____	
Asthma	☐Past	☐Present	Scarlet Fvr	☐Past	☐Present	**Weight:** _____	
Anemia	☐Past	☐Present	Sleep Prob	☐Past	☐Present	**Daily water intake?**	
Appendicitis	☐Past	☐Present	Skin Prob	☐Past	☐Present	_____ **oz**	
Cancer	☐Past	☐Present	Psychiatric	☐Past	☐Present		
Cold Sores	☐Past	☐Present	Stomach Prob	☐Past	☐Present		
Diabetes	☐Past	☐Present	Heart Prob	☐Past	☐Present		
Dizziness	☐Past	☐Present	Lung Prob	☐Past	☐Present		
Polio	☐Past	☐Present	Measles	☐Past	☐Present		
Epilepsy	☐Past	☐Present	Mumps	☐Past	☐Present		
TB	☐Past	☐Present	Pneumonia	☐Past	☐Present		
Ulcers	☐Past	☐Present	Pleurisy	☐Past	☐Present		

Describe any other conditions that are not listed above: _____

_____

_____

Describe any **yes** responses (ex: types of allergies, heart conditions, etc): _____

_____

_____

Have you ever suffered from a concussion? ☐ **Y** ☐ **N** If yes, when? _____

Describe any other major accidents or injuries (especially to the head, neck or back):

_____

Please circle any applicable past surgeries: ☐ **Tonsils** ☐ **Appendix** ☐ **Hernia** ☐ **Prostate** ☐ **Hysterectomy**

☐ **Other**: _____

Please list any prescription or over-the-counter medications you are currently taking:

_____

_____

_____

_____

Have you ever been on disability? ☐ **Y** ☐ **N** If yes, when? _____

Exercise Frequency:	☐Never	☐Seldom	☐Often	☐Frequent
Smoking Habits:	☐Never	☐Seldom	☐Often	☐Frequent
Alcohol Habits:	☐Never	☐Seldom	☐Often	☐Frequent
Coffee Habits:	☐Never	☐Seldom	☐Often	☐Frequent

Please indicate whether any family relative has ever had the following, and indicate <u>who</u>.

☐ Cancer _____	☐ Tuberculosis_____	☐ Anemia _____
☐ Diabetes_____	☐ Heart Disease_____	☐ Gout_____
☐ Seizures _____	☐ Suicide_____	☐ Arthritis_____

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_____ _____

Patient Name Date

_____ _____

Parent or Guardian (person filling out this form) **Relationship**

NEUROLOGICAL HISTORY

Please list any possible triggers for the onset of the problem(s):
(injury, vaccinations, illness, family crisis or changes, etc)

_____

_____

Please list any tests that have been performed and doctors seen to determine the nature of the problem(s):

Test:_____ Doctor:_____ Date: _____
Test:_____ Doctor:_____ Date: _____
Test:_____ Doctor:_____ Date: _____

Please indicate any diagnoses that have already been assigned for the problem(s):

☐ ADD	☐ Autism	☐ PTSD	☐ Other: _____
☐ ADHD	☐ Developmental Delay	☐ Dystonia	☐ Other: _____
☐ Dyslexia	☐ TBI/Concussion	☐ Stroke	☐ Other: _____
☐ OCD	☐ Tourette's Syndrome	☐ Fibromyalgia	☐ Other: _____

Please list any treatments already received for the problem(s) (Date order): _____

_____

_____

Please list any medications that have been taken for the problem(s):

_____Date Began: _____ Currently Taking? ☐ **Y** ☐ **N**
_____Date Began: _____ Currently Taking? ☐ **Y** ☐ **N**
_____Date Began: _____ Currently Taking? ☐ **Y** ☐ **N**

Please answer the following if the patient is a child:

What grade level is your child in? _____ Is your child on an IEP? ☐ **Y** ☐ **N**
If yes, explain: _____

Have you vaccinated your child according to the recommended schedule, or have you modified it?_____

_____

_____ _____

Signature of Patient or Legal Guardian Date

Brain Function Assessment Form™ (BFAF)

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 1

- A decrease in attention span **0 1 2 3**
- Mental fatigue **0 1 2 3**
- Difficulty learning new things **0 1 2 3**
- Difficulty staying focused and concentrating for extended periods of time **0 1 2 3**
- Experiencing fatigue when reading sooner than in the past **0 1 2 3**
- Experiencing fatigue when driving sooner than in the past **0 1 2 3**
- Need for caffeine to stay mentally alert **0 1 2 3**
- Overall brain function impairs your daily life **0 1 2 3**

SECTION 2

- Twitching or tremor in your hands and legs when resting **0 1 2 3**
- Handwriting has gotten smaller and more crowded together **0 1 2 3**
- A loss of smell to foods **0 1 2 3**
- Difficulty sleeping or fitful sleep **0 1 2 3**
- Stiffness in shoulders and hips that goes away when you start to move **0 1 2 3**
- Constipation **0 1 2 3**
- Voice has become softer **0 1 2 3**
- Facial expression that is serious or angry **0 1 2 3**
- Episodes of dizziness or light-headedness upon standing **0 1 2 3**
- A hunched over posture when getting up and walking **0 1 2 3**

SECTION 3

- Memory loss that impacts daily activities **0 1 2 3**
- Difficulty planning, problem solving, or working with numbers **0 1 2 3**
- Difficulty completing daily tasks **0 1 2 3**
- Confusion about dates, the passage of time, or place **0 1 2 3**
- Difficulty understanding visual images and spatial relationships (addresses and locations) **0 1 2 3**
- Difficulty finding words when speaking **0 1 2 3**
- Misplacement of things and inability to retrace steps **0 1 2 3**
- Poor judgment and bad decisions **0 1 2 3**
- Disinterest in hobbies, social activities, or work **0 1 2 3**
- Personality or mood changes **0 1 2 3**

SECTION 4

- Reduced function in overall hearing **0 1 2 3**
- Difficulty understanding language with background or scatter noise **0 1 2 3**
- Ringing or buzzing in the ear **0 1 2 3**
- Difficulty comprehending language without perfect pronunciation **0 1 2 3**
- Difficulty recognizing familiar faces **0 1 2 3**
- Changes in comprehending the meaning of sentences, written or spoken **0 1 2 3**
- Difficulty with verbal memory and finding words **0 1 2 3**
- Difficulty remembering events **0 1 2 3**
- Difficulty recalling previously learned facts and names **0 1 2 3**
- Inability to comprehend familiar words when read **0 1 2 3**
- Difficulty spelling familiar words **0 1 2 3**
- Monotone, unemotional speech **0 1 2 3**
- Difficulty understanding the emotions of others when they speak (nonverbal cues) **0 1 2 3**
- Disinterest in music and a lack of appreciation for melodies **0 1 2 3**
- Difficulty with long-term memory **0 1 2 3**
- Memory impairment when doing the basic activities of daily living **0 1 2 3**
- Difficulty with directions and visual memory **0 1 2 3**
- Noticeable differences in energy levels throughout the day **0 1 2 3**

SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects **0 1 2 3**
- Difficulty comprehending written text **0 1 2 3**
- Floaters or halos in your visual field **0 1 2 3**
- Dullness of colors in your visual field during different times of the day **0 1 2 3**
- Difficulty discriminating similar shades of color **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Brain Function Assessment Form™ (BFAF)

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 6

- Difficulty with detailed hand coordination **0 1 2 3**
- Difficulty with making decisions **0 1 2 3**
- Difficulty with suppressing socially inappropriate thoughts **0 1 2 3**
- Socially inappropriate behavior **0 1 2 3**
- Decisions made based on desires, regardless of the consequences **0 1 2 3**
- Difficulty planning and organizing daily events **0 1 2 3**
- Difficulty motivating yourself to start and finish tasks **0 1 2 3**
- A loss of attention and concentration **0 1 2 3**

SECTION 7

- Hypersensitivities to touch or pain **0 1 2 3**
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall **0 1 2 3**
- Frequently bumping into the wall or objects **0 1 2 3**
- Difficulty with right-left discrimination **0 1 2 3**
- Handwriting has become sloppier **0 1 2 3**
- Difficulty with basic math calculations **0 1 2 3**
- Difficulty finding words for written or verbal communication **0 1 2 3**
- Difficulty recognizing symbols, words, or letters **0 1 2 3**

SECTION 8

- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Bowel motility and movements slow **0 1 2 3**
- Bloating after meals **0 1 2 3**
- Dry eyes or dry mouth **0 1 2 3**
- A racing heart **0 1 2 3**
- A flutter in the chest or an abnormal heart rhythm **0 1 2 3**
- Bowel or bladder incontinence, resulting in staining your underwear **0 1 2 3**

SECTION 9

- A decrease in movement speed **0 1 2 3**
- Difficulty initiating movement **0 1 2 3**
- Stiffness in your muscles (not joints) **0 1 2 3**
- A stooped posture when walking **0 1 2 3**
- Cramping of your hand when writing **0 1 2 3**

SECTION 10

- Abnormal body movements (such as twitching legs) **0 1 2 3**
- Desires to flinch, clear your throat, or perform some type of movement **0 1 2 3**
- Constant nervousness and a restless mind **0 1 2 3**
- Compulsive behaviors **0 1 2 3**
- Increased tightness and tone in specific muscles **0 1 2 3**

SECTION 11

- Difficulty with balance, or balance that is noticeably worse on one side **0 1 2 3**
- A need to hold the handrail or watch each step carefully when going down stairs **0 1 2 3**
- Episodes of dizziness **0 1 2 3**
- Nausea, car sickness, or seasickness **0 1 2 3**
- A quick impact after consuming alcohol **0 1 2 3**
- A slight hand shake when reaching for something **0 1 2 3**
- Back muscles that tire quickly when standing or walking **0 1 2 3**
- Chronic neck or back muscle tightness **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Functional Brain Balance Questionnaire

PATIENT'S NAME: _____ DATE: _____

KEY: Circle the number that applies.

0 = Doesn't apply or you have not noticed this behavior before.
1 = Applies rarely (up to 2x monthly), is not a significant problem or is a mild "YES" to the statement.
2 = Applies fairly often (up to 3x weekly), is a considerable problem or is a moderate "YES" to the statement.
3 = Applies often (daily), is a really big problem or is a strong "YES" to the statement.

0 1 2 3 Procrastinates.	0 1 2 3 Tries to be funny all the time.	1
0 1 2 3 Is extremely shy, especially around strangers.	0 1 2 3 Is not good at following routines	
0 1 2 3 Seems to understand someone's emotions just by looking at them.	0 1 2 3 Drawn to a dancer, musician or actor type occupation	
0 1 2 3 Has to have a lot of change and variety in life.	0 1 2 3 Can't follow multiple-step directions.	
0 1 2 3 Tends to go along with the crowd and not rock the boat.	0 1 2 3 Expresses feelings by drawing rather than writing.	
0 1 2 3 Room, desktop or workspace is cluttered and/or disorganized.	0 1 2 3 Jumps to conclusions.	
0 1 2 3 Has poor self-esteem.	0 1 2 3 Tends to think or solve problems more creatively.	
0 1 2 3 Hates doing homework.	0 1 2 3 Prefers visual instruction with examples and/or becomes uneasy with long verbal explanations..	
0 1 2 3 Uses a lot of gestures when talking.		
0 1 2 3 Tends to think or solve problems logically.	0 1 2 3 Mimics sounds or words repeatedly without really understanding the meaning.	2
0 1 2 3 Often misses the gist of a story or joke.	0 1 2 3 Appears bored, aloof and abrupt.	
0 1 2 3 Gets stuck in thoughts or behaviors, can't let go.	0 1 2 3 Considered strange by other children and/or has an inability to form friendships.	
0 1 2 3 Lacks social tact, is antisocial and/or socially isolated or inappropriate.	0 1 2 3 Has difficulty sharing enjoyment, interests or achievements with other people.	
0 1 2 3 Poor time management, is always late.	0 1 2 3 Inappropriately giddy or silly.	
0 1 2 3 Disorganized.	0 1 2 3 Talks incessantly and asks the same questions repetitively.	
0 1 2 3 Has a problem paying attention	0 1 2 3 Has a tendency to turn head to right when asked question.	
0 1 2 3 Is hyperactive and or impulsive		
0 1 2 3 Argues all the time and is generally uncooperative.		
0 1 2 3 Drawn to a doctor, lawyer, or journalist type of occupation.		
0 1 2 3 Tends to see the big picture and misses details.	0 1 2 3 School work is inconsistent.	3
0 1 2 3 Is an intuitive thinker and is led by feelings.	0 1 2 3 Was a late talker and/or has difficulty saying long words.	
0 1 2 3 Tends to be able to grasp abstract concepts easily.	0 1 2 3 Has difficulty finishing homework or finishing a conversation.	
0 1 2 3 Poor analytical and/or academic skills.	0 1 2 3 Acts before thinking and makes careless mistakes.	
0 1 2 3 Has poor sense of time and/or trouble prioritizing.	0 1 2 3 Daydreams a lot.	
0 1 2 3 Doesn't read directions well and typically jumps into new things before instructions.	0 1 2 3 Has difficulty sequencing events in the proper order.	
0 1 2 3 Is naturally creative.	0 1 2 3 Is poor at basic math skills.	
0 1 2 3 Would rather do things instead of observe.	0 1 2 3 Has poor memorization skills and/or is a poor speller.	
0 1 2 3 Misreads or omits common small words.	0 1 2 3 IQ seems lower than expected and verbal scores are lower than nonverbal scores.	
0 1 2 3 Reads words very slowly and laboriously.	0 1 2 3 Stutters or stuttered when younger.	
0 1 2 3 Had difficulty naming colors, objects, and letters as a toddler.	0 1 2 3 Constantly questions why you're doing something.	
0 1 2 3 Needs to hear or see concepts many times in order to learn them and/or needs to be told to do something several times before acting on it.	0 1 2 3 Had difficulty learning the alphabet, nursery rhymes or songs when young.	
0 1 2 3 Often writes letters backwards.		
0 1 2 3 Doesn't consider the practical consequences of actions.	0 1 2 3 Speaks in a monotone voice (little voice inflection)	4
0 1 2 3 Misses the big picture.	0 1 2 3 Is a poor nonverbal communicator	
0 1 2 3 Very analytical.	0 1 2 3 Speaks out loud regarding what he or she is thinking	
0 1 2 3 Likes "slapstick" or obvious physical humor.	0 1 2 3 Talks "in your face" – is a space invader.	
0 1 2 3 Is very good at finding mistakes (spelling, etc.)	0 1 2 3 Good word reader but poor comprehension.	
0 1 2 3 Takes everything literally.	0 1 2 3 Good at keeping track of time.	
0 1 2 3 Doesn't always reach a conclusion when speaking.	0 1 2 3 Easily memorizes spelling and mathematical formulas.	
0 1 2 3 Started speaking early in life.	0 1 2 3 Poor math reasoning (word problems, algebra, etc.)	
0 1 2 3 Seems to have high IQ or has tested for a high IQ, but scores vary between different intelligence categories. (esp. above average in verbal ability and below average in performance abilities).	0 1 2 3 Enjoys observing rather than participating	
0 1 2 3 Was an early word reader.	0 1 2 3 Would rather read an instruction manual before trying something new.	
0 1 2 3 Is interested in unusual topics.	0 1 2 3 Is impatient.	
0 1 2 3 Learns in a rote (memorizing) manner.	0 1 2 3 Poor sense of balance.	
0 1 2 3 Learns extraordinary amounts of specific facts about a subject.		

0 1 2 3 Poor awareness of things on left side (bumps into things, etc)
0 1 2 3 Sensitivity to sound, light or touch (fireworks, bright lights, etc)
0 1 2 3 High threshold for pain (doesn't cry when gets hurt)
0 1 2 3 Likes to spin, go on rides, swing, etc. (anything with motion)
0 1 2 3 Touches things compulsively.
0 1 2 3 Extremely picky eater and/or is not interested in sweets.

0 1 2 3 Prefers bland foods.
0 1 2 3 Avoids food because of the way it looks.
0 1 2 3 Does not like the feel of clothing on arms or legs. (Pulls off clothes, etc.).
0 1 2 3 Does not notice strong smells (burning wood, popcorn, or cookies baking, etc.)
0 1 2 3 Delay or confusion when asked to point to a body part.

5

0 1 2 3 Is drawn to or overly likes strong tastes and/or smells.
0 1 2 3 Needs a lot of physical attention (hugged and held).
0 1 2 3 Enjoys touching and feeling actual objects.
0 1 2 3 Not very careful about what kinds of things he/she eats.
0 1 2 3 Very visual; loves images and patterns.
0 1 2 3 Poor awareness of things on right side (bumps into things, etc)

0 1 2 3 Likes the feel of various types of clothes or fabrics.
0 1 2 3 Delay in speaking was attributed to ear infections.
0 1 2 3 Seems not to hear well, although hearing tests are normal.
0 1 2 3 Gets motion sick and has other motion sickness issues.
0 1 2 3 More comfortable sitting on the right side of the room.

6

0 1 2 3 Clumsiness or/and odd posture.
0 1 2 3 Poor coordination.
0 1 2 3 Not athletically inclined and has no interest in participating in popular childhood sports.
0 1 2 3 Low muscle tone, muscles seem kind of floppy.
0 1 2 3 Fidgets excessively.

0 1 2 3 Poor gross motor skills (difficulty learning to ride a bike, runs and/or walks oddly, etc).
0 1 2 3 Repetitive motor mannerisms (rocks, spins in circles, flaps arms, etc.)
0 1 2 3 Poor eye contact.
0 1 2 3 Walks or walked on toes when younger.

7

0 1 2 3 Difficulty with fine motor skills (buttoning a shirt, poor or large handwriting, etc.)
0 1 2 3 Stumbles over words when fatigued.
0 1 2 3 Exhibited delay in crawling, standing, and/or walking.
0 1 2 3 Loves sports and is good at them.
0 1 2 3 Has good muscle tone

0 1 2 3 Poor drawing skills.
0 1 2 3 Difficulty learning to play music.
0 1 2 3 Likes to fix things with hands and is interested in anything mechanical.
0 1 2 3 Difficulty planning and coordinating body movements.

8

0 1 2 3 Spontaneously cries and/or laughs and/or has sudden outbursts of anger or fear.
0 1 2 3 Worries a lot and has several phobias.
0 1 2 3 Holds on the past "hurts".
0 1 2 3 Sometimes displays dark or violent thoughts.
0 1 2 3 Often seems fearless and is a risk taker.

0 1 2 3 Lacks emotional reciprocity.
0 1 2 3 Lacks empathy and feelings for others.
0 1 2 3 Experiences panic and/or anxiety episodes.
0 1 2 3 Has sudden emotional outbursts that appear over-reactive and inappropriate to the situation.

9

0 1 2 3 Overly happy and affectionate, loves to hug and kiss.
0 1 2 3 Frequently moody and irritable.
0 1 2 3 Loves doing new or different things but gets bored easily.
0 1 2 3 Lacks motivation.
0 1 2 3 Socially withdrawn and shy
0 1 2 3 Very sensitive to what others think about him or her.

0 1 2 3 Cries easily, feelings get hurt easily, and/or gets embarrassed easily.
0 1 2 3 Empathetic to other people's feelings, reads people's emotions well.
0 1 2 3 Excessively cautious, pessimistic, negative, and/or doesn't seem to get any pleasure out of life.

10

0 1 2 3 Gets chronic ear infections
0 1 2 3 Prone to benign tumors or cysts
0 3 Has taken antibiotics more than ten to fifteen times before the age of ten.

0 1 2 3 Catches colds frequently that last more than 2 days.
0 3 Has had tubes put in the ears.
0 1 2 3 Doesn't tend to have allergies.

I
11
A

0 1 2 3 Has (or had) an irregular heartbeat such as an arrhythmia or heart murmur.
0 1 2 3 Has difficulty seeing in low light.

0 1 2 3 Has (or had) bedwetting problems.
0 1 2 3 Gets hot or overheated a lot.

0 1 2 3 Has lots of allergies
0 1 2 3 Rarely gets colds and infections
0 3 Has or had eczema or asthma.
0 1 2 3 Skin has little white bumps, especially on the back of the arms.

0 1 2 3 Displays erratic health. (good one hour/day, bad the next)
0 1 2 3 Craves certain foods, especially dairy and wheat products.

I
12
A

0 1 2 3 Has (or had) a rapid heart rate and/or high blood pressure for their age.
0 1 2 3 Sweats a lot and/or has body odor.
0 1 2 3 Hands are always moist and clammy.

0 1 2 3 Problems with bowels, such as constipation and diarrhea, and/or appears bloated, especially after meals, often complaining of stomach pain.

13
For office use only.

14
For office use only.

Name: _____ Relation to Patient: _____

Signed: _____ Date: _____

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_____ _____
Patient Name Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and am informed that results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to: self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

_____ _____
Signature of Patient or Legal Guardian Date

ERISA AUTHORIZATION OF BENEFITS

For good and valuable consideration, I _____, do hereby designate, authorize and convey to Seacrest Health and Wellness Center, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee health care benefit plan; and b) the right and ability to act on my behalf to pursue such claim, right or chose in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR§2560.5031(b)(4)) with respect to any medical or other health care expense incurred as a result of the services I received from the above-named center and, to the extent permissible under the law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

_____ _____
Signature of Patient or Legal Guardian Date

SEACREST
Health & Wellness Center

Dr. Will Rogers, DC, DACNB
Dr. Dean Peppard, DC
www.SeacrestHWC.com

10953 Meridian Dr. Ste. O
Cypress, CA 90630
714-821-4265

Patient Name _____ Date _____

Initial	FINANCIAL RESPONSIBILITY & CANCELLATION POLICY
↓	By accepting services or products from SHWC, you are agreeing that you are financially responsible for such services or products. ***Fees are due at time of service, regardless of insurance. We are out of network with all insurance companies.*** If you miss your appointment without 24-hour prior notice, we reserve the right to charge for the time we had reserved for you. **Cancellation fee is 50% of the service fee.** You, and not your insurance company or attorney, are directly responsible for any cancellation fees incurred. Fees will be collected upon your next visit to the office or billed to your address.
Initial	**BILLING POLICY**
↓	We can either give you an itemized statement which you can submit to your insurance company, or have our outside billing service bill it for you. ***Using our outside billing service it is possible to not receive a response from the insurance company for up to 90 days.*** Your insurance company will send the reimbursement to our office and we will refund your money or apply the balance in a prepayment arrangement with you. The billing service charges 7% on all funds collected from the insurance company. This charge is deducted from the refund given by the insurance company. The 7% charge does not apply to Medicare billing as it is federally mandated, but will apply to secondary insurance. ***There is no guarantee that insurance will reimburse, even with benefit verification.***
Initial	**PRIVACY NOTICE**
↓	As required by the Privacy Regulations, SHWC **may not use or disclose** your protected health information without your authorization. In order to provide you with maximum care, we might need to discuss your case within our office or other outside consultant resources. We keep your health information safe and separate from your financial information. You can revoke or change this authorization at anytime by sending a written notice to our office. Our full *HIPPA Privacy Notice* is available for you and is posted in our office; Feel free to ask our staff any question regarding that matter. By signing here, you will provide SHWC your authorization to disclose your healthcare information for the purposes of treatment, payment and healthcare operations as described in the *Privacy Notice.* You may authorize us to share your information with someone by designating that person and naming them here: Name: _____. Relationship:_____.
Initial	**PHOTO & VIDEO RELEASE**
↓	We often document our examinations for further analysis. We use standard recording equipment and there are no hidden recording devices in our facility. By signing here, you grant permission to the rights of your image, likeness and sound of your voice as recorded on audio or videotape without payment or any other royalties. This material may be used for internal review, pre/post analysis and in diverse educational settings within an unrestricted geographic area. There is no time limit on the validity if this release and it applies to photo, audio or video recording collected as part of our diagnostic and treatment process.

Signature: _____ **Date:** _____

CONSENT TO TREATMENT OF MINOR CHILD

Child's Name: _____ **Date:** _____

Guardian's Signature: _____ **Relationship:** _____