

Welcome to FINGER LAKES FAMILY CHIROPRACTIC & WELLNESS!

Our mission is to educate and empower families in our community toward true wellness and help them achieve optimal health, healing, and performance through natural and gentle chiropractic care.

PATIENT INFORMATION

Print Full Name _____ Today's Date _____
Street Address _____ City _____ State _____ Zip _____
Age _____ Date of Birth _____ E-Mail: _____
Social Security #: _____ Would you like to receive our free e-mail newsletter each month? Yes / No
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
Occupation _____ Employer _____
Emergency contact (name) _____ How they could be reached: _____
Marital Status S M D W Name of Spouse / Significant Other _____
Names and Ages of Children _____
Whom may we thank for referring you to our office? _____

WELLNESS OBJECTIVES

WHY THIS FORM IS IMPORTANT: It is always best to begin with the end in mind. As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our immediate goal is to determine what may be interfering with your ability to express health. In addition, it is our goal to figure out if your current state of health and the issues that brought you here are the result of **SUBLUXATIONS**, or areas of neurospinal stress.

Our services aim to offer you and your family the opportunity for a lifetime of health, happiness and vitality. *To better understand your individual health objective, please check all items listed that best describe your health goals:*

- Maximum Correction of the Problem Restored Health Symptom / Temporary Relief Only
- More Energy Better Sleep Overall Wellness (maximum expression of health)
- Prevention of Future Problems Improved Performance Decreased Reliance on Medications
- Improved Posture and Flexibility Stronger Immunity Other: _____

On a scale of 0-100, with "0" representing "Illness/Breakdown/Absence of Health" and "100" representing "Wholeness / Optimal Function / Peak Potential", please rate your current level of health: _____

Where would you like to be on that scale? _____
How much time do you feel is needed to reach that point? _____
What strategies do you plan to use to achieve that level? _____

ADDRESSING YOUR BODY SIGNALS / HEALTH CHALLENGES

Pain and symptoms are important signals that give clues about the problem at hand. If you are concerned about a specific health concern or body signal, please describe it, including location and when and how it began:

Frequency: How often do you have the above complaint(s): _____

Quality (please circle all that apply): sharp, dull, throbbing, burning, numb, achy, other: _____

Time: What time of day do you notice it most? _____

What makes it feel better? _____

What makes it feel worse? _____

What do you think the problem is? _____

Is it getting better or worse? _____

Is this complaint/concern affecting your quality of life? (Please circle only those applicable to you)

Work	Recreation	Sleep	Daily Routine	School	Relationships
Walking	Sitting	Mood	Exercise/sports	Eating	Energy

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Yes/No With whom? _____

How long under care? _____ Date of last visit: _____ Why did you stop? _____

Please list other health providers you have consulted with in the last 5 years: _____

PAST HEALTH HISTORY

Please circle any of the following that you have experienced:

<i>Asthma</i>	<i>Allergies</i>	<i>Heart Disease</i>	<i>Stroke</i>	<i>High Blood Pressure</i>
<i>Cancer</i>	<i>Diabetes</i>	<i>Osteoporosis</i>	<i>Arthritis</i>	<i>Fibromyalgia</i>

Please list any others diseases or conditions that you have had throughout your life: _____

Please list all medications you currently take and the reason for taking: _____

Please list any nutritional supplements you take: _____

FINANCIAL INFORMATION

PLEASE READ AND SIGN BELOW

It is understood and agreed that the amount paid for x-rays is for examination only and that the films are the property of the office and are on file where they may be seen at any time while I am an active patient in this office. I may obtain copies of my file upon request. Copying fees may apply.

I understand and agree that I am responsible for payment in full for all services rendered on the FIRST VISIT.

I agree that the information submitted on this form is true and accurate to the best of my knowledge.

Signature: _____

Date: _____

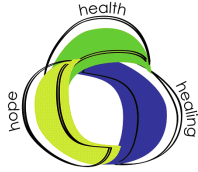
Medicare Patients Only

Medicare pays for services rendered on a medical necessity basis. They may or may not pay up to 12 visits per calendar year for chiropractic care. This is decided after they have reviewed your case.

I have read the above paragraph and understand that if Medicare does not find my case a medical necessity, I know that I am responsible for all services rendered.

Signature: _____

Date: _____



Finger Lakes Family Chiropractic & Wellness

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www.fingerlakeschiro.com

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Pregnancy Release (*For All Females*):

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

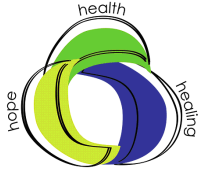
Date

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature

Date



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Notice of Privacy Practices (HIPAA)

Effective Date: This notice is in effect as of November 1, 2007

Acknowledgement: *I have been offered to review a copy of the "Notice of Privacy Practices" of Finger Lakes Family Chiropractic & Wellness.*

Name (Print)

Signature

Date

Signature of Personal Representative, Relationship

Date

Witness

Date