Welcome to FINGER LAKES FAMILY CHIROPRACTIC & WELLNESS!

Our mission is to help as many people as possible live a longer, healthier, and happier life – especially children!

PATIENT INFORMATION

Print Full Name_____ Today's Date _____

Street Address_____ City _____ State_____ Zip _____

Age _____ Date of Birth _____ E-Mail:_____

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?_____

FUTURE WELLNESS GOALS

Please check all items listed that best describe your health goals:

__Maximum Correction of the Problem __Restored Health __Symptom Relief
__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 __Stress Reduction
__Improved Nutrition / Fitness / Body Composition __Other:_____

On a scale of 0-100, where "100" represents your ideal level of health, where you feel your best and have the quality of life you desire and are optimistic about your future health, please indicate where you are today: _____

How much time do you feel is needed to restore your health to an optimal level?_____

What strategies do you plan to use to achieve that level?_____

_____

Over the last 5 years, my health and quality of life has: Decreased / Stayed the Same / Improved

Has a doctor ever created a health restoration or health development plan for you? YES / NO

On a scale of 1-10, what is your level of commitment to reaching your health and wellness goals? _____

PRESENT CONCERNS AND PREVIOUS CHALLENGES

Please describe your current concern, including its **location** and **when** and **how** it began (If you have no current concerns, please turn page over and continue):_____

_____

Frequency: How often do you experience the above concerns: *Hourly / Daily / Weekly / Monthly / Other*

Quality: *sharp / dull / throbbing / burning / numb / achy / tingling / other*:_____

Time: When do you notice it most? *Morning / Afternoon / Evening / Overnight*

What makes it feel **better**?_____ **Worse**?_____

What do you think the problem is? _____

What do you attribute your **current level of health** to: *Lifestyle / Poor Planning / Bad Genes / Bad Luck / Stress / Lack of Understanding and Direction / Physical Trauma / Age / Other:*_____

Which areas of your life are affected by your current level of health?

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

Please circle any of the following body signals that you have experienced more than once in the last 10 years:

Headaches	Poor Concentration	Poor Balance	Neck Pain	Ringing in Ears
Light Sensitivity	Diminished Smell/Taste	Sinus Problems	Dizziness	Insomnia
Thyroid Imbalance	Pins & Needles in Arms	Numbness in Fingers	Nervousness	Sore / Dry Throat
Restlessness	Chronic Fatigue	Shortness of Breath	Poor Circulation	Mid-back Pain
Constipation	Diarrhea	Burning in Stomach	Muscle Tension	Irritable Bowel / Gut
Low Back Pain	Pins & Needles in Legs	Numbness in Toes	Infertility	Erectile Dysfunction
Depression	Anxiety	Restless Legs	Leaky Bladder	Flushness

Do you understand how these body signals may be related to the function and alignment of your spine? **YES / NO**

Please indicate any "**diagnosed**" health conditions that you have experienced:

Asthma	*Allergies*	*Heart Disease*	*Stroke*	*High Blood Pressure*	*Cancer*
Diabetes	*Osteoporosis*	*Arthritis*	*Fibromyalgia*	*Other:*_____	

STRESSORS

- Throughout your life, what have been some of the major **physical stressors** your body has experienced? (Think about slips, falls, car crashes, sports injuries, long periods of sitting, leisurely mishaps, work injuries, etc)_____

_____

-How would you rate the amount of **emotional stress** you have faced throughout your life*: Low / Mild / Moderate / Severe*

-Please list all medications (Rx and OTC) you currently take and the reason for taking (dosage not necessary):

_____

_____

Will you have to take these medications for life or does your doctor have a plan to stop them?_____

-Please list any nutritional supplements you take:_____

Do you consume more than 60 ounces of water each day? YES / NO *Any regular tobacco use in last 10 years?* YES / NO

Do you consume diet drinks / sugar-free products? YES / NO *Daily caffeine intake?* YES / NO

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 **doctors / health providers** you have consulted with in the last 5 years:_____

_____

Additional Information: _____

_____

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

Signature:_____ **Date:**_____

Finger Lakes Family Chiropractic & Wellness

324 W. North Street, Suite 1
Geneva, NY 14456

Phone: (315) 789-WELL (9355)
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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)

Your privacy is important to us and we have created a strict policy to protect all aspects of patient confidentiality. By signing this notice, you acknowledge that Finger Lakes Family Chiropractic & Wellness (FLFCW) has a copy of their "Notice of Privacy Practices" available for your review at any time.

(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 FLFCW.*

Name (Print)	Signature	Date
Signature of Parent / Guardian / Personal Representative		Date
Witness / FLFCW Team Member		Date

Office Fee Schedule and Financial Policy

Consultation: Complimentary
X-Rays (per view): $35
Chiropractic Adjustment: $40
Computerized Neurospinal Stress Scans: $25-$90
Comprehensive New Patient Exam: $145 (inc. all x-rays and scans)
Subjective Progress Evaluation: $25

PLEASE READ AND SIGN BELOW

FLFCW is dedicated to our practice members and committed to providing the highest quality wellness care to help you get well and stay well naturally. The care in our office is an excellent investment in an individual's well being. We believe financial considerations should never be an obstacle to obtaining the care you need and deserve. We have affordable options to help eliminate any financial barriers.

In today's healthcare system, insurance participation can be confusing. It will be our pleasure to verify your chiropractic benefits for you. Many insurance companies provide some coverage for the services we offer in this office. Coverage varies and you may have limitations on the number of paid visits, deductibles or exclusions and may or may not have coverage. FLFCW is not a participating provider with any insurance company including PPO's, HMO's, or Medicare. This office does not promise that any insurance company will reimburse you for the usual and customary charges submitted by this office.

You are considered a cash practice member until our office "qualifies" your coverage to determine the extent of benefits under your policy. Members and their guardians are responsible for the payment in full of all fees for service. Unless other arrangements are made, payment is expected at the time of service regardless of insurance coverage.

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

At FLFCW, we never want a financial challenge to get in the way of a family receiving care in our office. Therefore, we have established a fee schedule that creates affordable options for members. We are ready, willing, and able to assist you!

Please select form of Payment for today's visit: CASH / CHECK / VISA / MASTERCARD / FSA / HSA

Printed Name:_____

Signature: _____ **Date:**_____