## 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

Child's Name_____ Today's Date _____

Nickname_____ Parent(s) Names _____

Parent: Home Phone (___) _____Cell Phone (____) _____ Work Phone (___) _____

Street Address_____ City _____ State_____ Zip _____

Age _____ Date of Birth _____ Social Security # _____Height _____ Weight _____

Pediatrician / Other Professionals Visited: _____

### REASON FOR SEEKING CARE

**In order to best serve your child, it is important to know what your goals are for them. Please check all that apply to your child:**

__Maximum Correction of the Problem __Improved Focus and Concentration __ Better Sleep
__Healthy Growth and Development __Prevention of Future Problems __Improved Performance
__Decreased Reliance on Medications __Improved Posture and Flexibility __Stronger Immunity
__Symptom / Temporary Relief Only __Overall Wellness (maximum expression of health)
__Other:_____

**Interference to normal function can cause many different signs and symptoms. Our goal is to determine if SUBLUXATIONS (areas of neurospinal stress) are playing a role in your child's current level of health. Please indicate if your child has been affected by any of the following health challenges:**

___ Ear Infections ___ Scoliosis ___ Seizures ___ Chronic Colds
___ Asthma ___ Allergies ___ Digestive Problems ___ ADHD
___ Recurrent Fevers ___ Colic ___ Bed Wetting ___ Headaches
___ Sleeping Problems ___ Growing Pains ___ Accident ___ Motor Problems
___ Neck Problems ___ Back Problems ___ Other:_____

### HEALTH, WELLNESS, AND CHIROPRACTIC CARE

**The following questions will give us a profile of the specific stresses your child has faced in his / her lifetime. Physical, emotional and chemical stresses can accumulate over time and result in a *serious loss of health potential*. Often, the effects are gradual and may linger for years without any signs and symptoms. Learning about these stresses will help us to better understand their current level of health.**

### PREGNANCY, LABOR, AND DELIVERY HISTORY

Location of Birth (*please circle*): Home / Birthing Center / Hospital / Other: _____

3rd Trimester Presentation: Vertex / Breech / Transverse / Facial / Brow

Type of Birth: Vaginal / Forceps / Cesarean / Vacuum / Suction

List any congenital anomalies / birth defects _____

## HISTORY OF CHEMICAL STRESS

Infant Feeding: Breast / Bottle If bottle, which formula? _____

From the time of conception, was your child exposed to any second hand smoke? YES / NO

During pregnancy, did mother consume any alcohol? YES / NO Cigarettes? YES / NO

Does your child consume fast food: Daily / Weekly / Bi-Weekly / Monthly / Never

Does your child consume soda: Daily / Weekly / Bi-Weekly / Monthly / Never

Does your child consume fruit juices: Daily / Weekly / Bi-Weekly / Monthly / Never

Does your child consume processed foods: Daily / Weekly / Bi-Weekly / Monthly / Never

Number of antibiotics in last 6 months: _____ Lifetime: _____

Number of Vaccines in Lifetime: _____ Any Adverse Reactions to Vaccines: YES / NO

List Any Prescription or OTC Medications in last 12 months:_____

_____

## HISTORY OF EMOTIONAL / PSYCHOLOGICAL STRESS

Have you noticed any behavioral problems? _____

# of hours your child sleeps during day: _____Night: _____ Rate their quality of sleep: Poor / Fair / Good / Excellent

Number of hours daily spent at TV, computer, or playing video games: _____

Does your child have difficulty socializing? _____

Does your child have difficulty concentrating? _____

## HISTORY OF PHYSICAL STRESS

Any signs of birth trauma?_____

List any surgeries or hospital visits: _____

What sports does your child participate in? _____

List any sports-related injuries: _____

List any falls from cribs, changing tables, high chairs, stairs, etc: _____

Any car accidents: _____

Weight of your child's backpack: _____ Any other physical traumas: _____

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

Signature:_____ Date:_____

(Parent / Legal Guardian)

# Finger Lakes Family Chiropractic & Wellness

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

Phone: (315) 789-WELL (9355)
Fax: (315) 789-9300
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:**_____