Welcome to FINGER LAKES FAMILY CHIROPRACTIC & WELLNESS!

Providing performance-based chiropractic care for pediatric development and adult wellness!

PATIENT INFORMATION

Name:_____ Date:_____

Reason for consulting our office: A) Improve overall wellness, B) Address specific concern, C) Both

Street Address:_____City / State / Zip:_____

E-Mail:_____ Age:_____Date of Birth:_____

Home Phone:(___)_____Cell Phone:(___)_____Work Phone:(___)_____

Marital Status S M D W Name of Spouse / Significant Other:_____

Names and Ages of Children:_____

Occupation:_____Employer:_____

Emergency Contact:_____ How they could be reached:_____

Whom may we thank for recommending you to our office?_____

PRESENT CONCERNS AND GOALS FOR CARE:

Please share what you are hoping to accomplish by working with our office:_____

_____

Why did you choose *wellness chiropractic care* (vs. other interventions) to help you accomplish this objective?____

_____

If you are experiencing a specific symptom or challenge, please answer the following questions:

(If you this does not apply to you, please skip to the next section on "ADDITIONAL HEALTH OBJECTIVES")

Where is it located?_____

When did it begin?_____

How did it begin?_____

How often do you experience it: *Hourly / Daily / Weekly / Monthly / Other*

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

How would you describe it? *sharp / dull / throbbing / burning / numb / achy / tingling / other*:_____

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

What do you think is causing this symptom / challenge? _____

What concerns you most about this symptom / challenge?_____

Please indicate which ADDITIONAL HEALTH OBJECTIVES you'd like to achieve:

__ More energy	__ Better sleep	__ Freedom from pain
__ Better concentration	__ Enhanced emotional well-being	__ Reduce/eliminate medication use
__ Improved digestion	__ Improved strength and endurance	__ Greater resistance to disease
__ Easier breathing	__ More balanced posture	__ Overall health improvement
__ Deeper relaxation	__ Better sports performance / reaction time / reflexes	

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

What **strategies** do you feel are necessary to achieve those goals?_____

_____

How much **time** do you feel is needed to *achieve your health and wellness goals*?

Less than 1 month / 1-3 months / 3-6 months / 6-12 months / 12+ months

YOUR HEALTH PROFILE:

What do you consider your **3 best health habits**?_____

What do you consider your **3 worst health habits**?_____

Please grade yourself from 0-100 in the following areas (with 100 representing your ideal):

Overall Health:_____Diet:_____ Rest:_____Exercise:_____ Alignment: _____ Mindset:_____

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

Why is it **important** for you to be healthy?_____

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

Which areas of your life are impacted or limited by your current level of health?

Work Performance	*Relationships*	*Energy*	*Sleep*	*Travel*	*School*
Focus / Concentration	*Exercise Routine*	*Mood*	*Intimacy*	*Social Life*	*Recreation*

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

1._____ 2._____ 3._____

4,_____ 5._____ 6._____

Please list any nutritional supplements you take:_____

Please indicate which aspects of **supportive care / wellness education** you are most interested in:

__ Nutritional Supplements __ Basic Exercise Strategies __ Postural Support __ Planning for Longevity

__ Disease Prevention __ Advanced Exercise Strategies __ Goal Setting __ Pediatric Health

__ Strategies for a Healthy and Constructive Mindset __ Sleep Support __ Stress Management

PREVIOUS HEALTH HISTORY

Please indicate any health conditions that you have been diagnosed with:

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

Please indicate which *WELLNESS DANGER SIGNALS* you have experienced over your lifetime for either a) an extended period of time (aka weeks / months/ years) *OR* b) on more than a few occasions:

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

*Do you understand how these body signals are related to your spine and nerve system? **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:_____

_____

Is there any additional information you'd like the doctor to be aware of?_____

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

Signature:_____ **Date:**_____

Office Use Only:_____

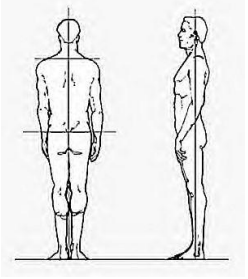
_____

_____

_____

Dec ROM: CF / CE / LHR / RHR / LHF / RHF / LF / LE / RLF / LLF

Tests Ordered: Therm / EMG / ROM / HRV / Foot Scan / Lat cerv / AP cerv / Lat Lumb / AP Lumb



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 (Please read and sign below)

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.

Name:_____**Signature:** _____**Date:**_____

Consent to evaluate and adjust a minor child (complete for children under 18 years old):

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:**_____

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**: _____

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Notice of Privacy Practices (HIPAA) (Please read and sign below)

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:_____ **Signature**:_____ **Date**:_____

Parent /Guardian /Representative Signature (*if necessary)*:_____ **Date**:_____

Please list the names of any person(s) you authorize the release of your health information to:
1. _____ 2. _____ 3. _____

Witness / FLFCW Team Member:_____ **Date**:_____

Office Fee Schedule and Financial Policy (Please read and sign below)

Consultation:	Complimentary	*Computerized Neurospinal Stress Scans*:	$40
Chiropractic Adjustment:	$40	*Comprehensive New Patient Exam*:	$80-$120
Progress Evaluation:	$40	*Missed Visit* (if office not notified in advance):	$25
X-Rays (per series):	$40	*Retuned Check / EFT*:	$15

Paying for Care: FLFCW is committed to providing the highest quality family wellness care to help you get well and stay well naturally. The care in our office is an excellent investment in your present and future well-being and is surprisingly affordable. We believe that cost / finances should never be an obstacle to obtaining the care you need and deserve. If, after your consultation and evaluation, you elect to benefit from the care we recommend, you will be able to choose from a variety of affordable payment options to help eliminate any financial barriers. Discounted plans and family plans are available. We are ready, willing, and able to assist you!

Insurance: The purpose of most insurance policies is to support you through acute / crisis care, but not through wellness development care. Many of our practice members do receive coverage for a portion of their care and it will be our pleasure to verify your chiropractic benefits for you before any care is rendered. Your insurance coverage will be based on your out-of-network benefits, which in many cases are equal to or even less than your in-network co-pay. This office cannot make any guarantees about insurance reimbursement, as ultimately your contract is between you and your insurance carrier. Flexible Spending Plans and Health Savings Accounts can also be used.

X-Rays: Federal law requires that our office maintains possession of any x-rays obtained in this office. Your x-rays will be on file and can be seen be seen at any time while you are an active member of this practice. You may also sign out your films to another provider for up to thirty (30) days.

Medicare: Our office is a non-participating Medicare provider. Medicare patients are required to pay cash as services are rendered and we will submit your claims as a courtesy to you. Medicare patients must present their Medicare card at the onset of care. The only service Medicare covers is Acute Care.

"By signing below, I acknowledge that I am financially responsible for any services rendered in this office to me or my dependents and I agree to submit payment at the time of service unless other signed financial arrangements are made."

Name:_____ **Signature:** _____ **Date:**_____

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