Welcome to FINGER LAKES FAMILY CHIROPRACTIC & WELLNESS!

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

PATIENT INFORMATION

Child's Name_____ Nickname _____Today's Date_____

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

Date of Birth_____ Age_____ Parent(s) Names _____

Address:_____City / State / Zip:_____

Height / Weight:_____ Pediatrician:_____

Other Doctors / Health Practitioners: _____

Has your child ever received Chiropractic care? Yes/No With whom?_____

PRESENT CONCERNS AND GOALS FOR CARE

How would you like your child to benefit from chiropractic care?_____

_____

If your child is 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 they experience it: *Hourly / Daily / Weekly / Monthly / Other*

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

How would they 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 for your child to achieve:

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

What concerns you most about your child's current or future health?_____

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

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

What is your understanding of how chiropractic care helps kids? _____

HEALTH HISTORY

Please describe any health concerns your child experienced during infancy & early childhood (0-6 years):_____

_____

_____

Please describe any health concerns your child experienced during late childhood (7-12 years):_____

_____

_____

Please list all medications (Rx and OTC) your child currently takes and the reason (dosage not necessary):

1._____ 2._____ 3._____

Please list any nutritional supplements your child takes:_____

Please indicate any of the following body signals or health concerns that your child has experienced:

__ Ear Infections __ Scoliosis __ Seizures __ Chronic Colds __ Asthma
__ Digestive Problems __ Allergies __ ADD /ADHD __ Recurrent Fevers __ Colic
__ Bed Wetting __ Headaches __Growing Pains __ Motor Problems __ Neck Pain
__ Back Pain __ Trouble Sleeping __ Speech Difficulties __ Other:_____

Please **circle** any factors that you believe are contributing to your child's current level of health:

*In Utero Complications or Stressors / Injury During Delivery / Physical Trauma or Injury / Poor Posture / Lack of Exercise / Emotional Stress / Family Challenges / Stress at Home / Social Influences / Poor Planning / Poor Nutrition / Food Allergies / Vaccine or Medication Side Effects / Exposure to Toxins / Genetics / Bad Luck / Poor Habits / Other:*_____

HISTORY OF PHYSICAL, CHEMICAL, AND EMOTIONAL STRESS

The following questions will give us a profile of the specific stresses your child has faced in his / her lifetime that may be related to their current condition or which may impact their future well-being.

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

Child's3rd Trimester Position: Vertex (Head Down) / Breech (Head Up) / Transverse (Side-Lying) / Facial (Head Extended) / Brow (Head Extended) Type of Birth: Vaginal / Forceps / Cesarean / Vacuum / Suction

Were there any signs of birth trauma? YES / NO List any congenital anomalies / birth defects:_____

APGAR Score:_____ Did mom have any difficulties during pregnancy? YES / NO. Please list:_____

Please list any surgeries or hospital visits: _____

What sports does your child participate in? _____

Please list any sports-related injuries: _____

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

Please describe any car accidents your child has been in: _____

Please list any other physical traumas:_____

# of hours daily spent at TV, computer, or playing video games:_____ How much does their backpack weigh?____

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

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

During pregnancy, did mom consume: **Alcohol**? YES / NO **Cigarettes**? YES / NO **Rx/OTC** meds? YES / NO

How often does your child have: **Fast Food:** Daily/ Weekly/Monthly/Never **Soda**: Daily / Weekly / Monthly / Never

Fruit Juices: Daily / Weekly / Monthly / Never **Processed / Packaged Food:** Daily / Weekly / Monthly / Never

of **Antibiotics** in Lifetime:_____ # of **Vaccines** in Lifetime:_____ Any Adverse Reactions to Either: YES / NO

List any Rx/OTC medications taken in last 12 months that were not listed above:_____

_____

Does your child have **behavioral problems**? YES/NO **Difficulty socializing**? YES/NO **Difficulty concentrating**? YES/NO

# of hours your child sleeps: Day____ Night____ Rate their quality of sleep: Poor / Fair / Good / Excellent

Please rate the level of stress in your household on a scale of 1-10, with 10 being "extremely high": _____

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:**_____
(Parent / Legal Guardian)

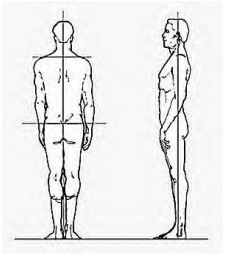
Office Use Only: _____

_____

_____

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 **Fee:**_____



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