

Welcome To Fimreite Chiropractic

Child's First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age ____ Today's date ____/____/____
Address _____ City _____ State _____ Zip _____
Male ____ Female ____ Weight _____ Height _____ Social Security # _____ Home # () _____
Mom's Cellular # () _____ Dad's Cellular # () _____ Alternate Phone # () _____
Mom's Email: _____ Dad's Email: _____
School Name _____ Grade _____
Name of Parents _____ Birth Date of Parent (carrying insurance) ____/____/____
Who may we thank for referring you to our office? _____

Child's Health Profile

Reason for seeking chiropractic care _____
When did you first notice this problem? _____ Have you had this problem before? ____ No ____ Yes
Has your child even been involved in a motor vehicle accident (even if passenger and/or no perceived injuries) YES / NO _____
Has your child ever been to the Emergency Room YES / NO If YES, please explain: _____
Surgeries _____ Other Traumas _____
Participate in activities that require prolonged, awkward, high impact or repetitive postures? (cheerleading, football, violin, gymnastics, martial arts) YES / NO Hours per week _____ Explain Injuries _____
Weight of school backpack _____ Do they walk to/from school YES / NO If YES, how far _____
Average number of hours per week Sitting in Front of Computer _____ Playing Video Games _____ Watching Television _____

mark "X" for **PRESENT** CONDITIONS, mark "PA" for **PAST** CONDITIONS (3 months or longer), (please 'Circle' if necessary to be more specific)

<input type="checkbox"/> Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both	<input type="checkbox"/> Hip Pain R / L	<input type="checkbox"/> Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L Both
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Neck Stiffness/Pain
<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Frequent Colds/Flu/Fever
<input type="checkbox"/> Swollen Painful Joints	<input type="checkbox"/> Tremors	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Blurred Vision R / L
<input type="checkbox"/> Pain w/ Cough/Sneeze	<input type="checkbox"/> Stroke	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Buzzing/Ringing in ears	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Depression	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Irritability/Mood Swings
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Stomach Upset
<input type="checkbox"/> Cold feet	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Recurring Infection
<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Jaw/TMJ Problems
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> PMS	<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Asthma/Allergies	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Colic	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Other _____	<input type="checkbox"/> Seizures	<input type="checkbox"/> Broken Bones
	<input type="checkbox"/> Cancer (type) _____	<input type="checkbox"/> Back Stiffness/Pain
		<input type="checkbox"/> Diabetes
		<input type="checkbox"/> Cancer
		<input type="checkbox"/> Double Vision R / L
		<input type="checkbox"/> Loss of Taste
		<input type="checkbox"/> Digestive Problems
		<input type="checkbox"/> Insomnia
		<input type="checkbox"/> Nervousness/Anxiety
		<input type="checkbox"/> Tension/Stresses
		<input type="checkbox"/> Teeth Grinding
		<input type="checkbox"/> Diarrhea/Constipation/Gas
		<input type="checkbox"/> Scoliosis
		<input type="checkbox"/> Temper Tantrums
		<input type="checkbox"/> ADHD/ADD
		<input type="checkbox"/> Growing/Back Pain
		<input type="checkbox"/> Falls

Have you ever been to a chiropractor before? Y / N If YES, your last adjustment? _____ Techniques successful? _____
What spinal maintenance program were you given to follow to maximize the future stability of your spine? _____

Patient Name: _____

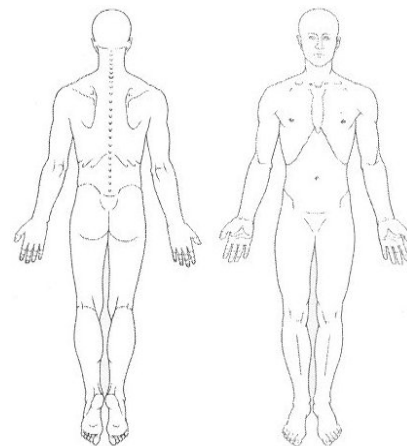
Date: _____

Please be sure to fill this section extremely accurately. On the diagram to the right, mark the area on your body where you feel the described sensation(s). Use the appropriate abbreviation(s), mark areas of radiating pain. Use the abbreviation(s) repetitively if needed and include all areas.

Dull Pain = D
Ache = A
Sharp Pain = S

Numbness = N
Tingling = T
Weakness = W

Stiffness = SF
Burning/Throbbing = B
Gripping = G



On the scale below, indicate the area (i.e. neck, low back) that most accurately represents your pain or discomfort. 0 is no pain/discomfort and 10 is worst possible pain/discomfort. Please circle if the pain/discomfort is constant or intermittent.

Area: _____ OnAverage: _____/10; AtWorst: _____/10 Constant or Intermittent
Area: _____ OnAverage: _____/10; AtWorst: _____/10 Constant or Intermittent
Area: _____ OnAverage: _____/10; AtWorst: _____/10 Constant or Intermittent

DAILY ACTIVITIES DISCOMFORT: Effects of Current Condition on Performance

Walking	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sitting	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sleeping	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Running/Jogging	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Reading	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Watching TV	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sitting at Computer/Desk	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sports/Gym	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable

Medications: What medications are you currently taking and for what conditions? _____

DEVELOPMENTAL HISTORY

Birth traumatic (excessive pulling/twisting) YES / NO
___Drug Induced ___Forceps or Suction ___"C" Section ___Cord around neck ___Breech ___Prolonged ___Natural
Complications during Pregnancy YES / NO List _____ Ultrasounds during pregnancy YES / NO How many _____
Cigarette / Alcohol during pregnancy: YES / NO Genetic Disorders or disabilities _____
Birth Weight _____ Birth Length _____ APGAR Scores _____ Breast Fed YES / NO How Long _____
Formula Fed YES / NO How Long _____ Introduced to solids at _____ months Cows milk at _____ months
Food/Juice allergies or intolerances YES / NO _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, downstairs, etc.) Was this the case with your child? YES / NO

During times listed below is a time your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

___Respond to Sound ___Respond to Visual Stimuli ___Hold Head Up ___Sit Up ___Cross Crawl ___Stand ___Walk Alone

Please note which vaccinations your child has received:
___MMR ___DPT ___Chicken Pox ___Polio ___Hemophilus Influenza B ___Hepatitis B Other _____
___ NO Vaccinations ___ Adverse Reactions to Vaccinations (please explain): _____

Childhood Diseases:
Chicken Pox YES/NO Age _____ Mumps YES/NO Age _____ Rubella YES/NO Age _____ Whooping Cough YES/NO Age _____
Age of first menstruation _____ Age Puberty started _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Signature

Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

(Signature)

(Date)

**Fimreite Chiropractic, 4727 Willow Springs Road
La Grange, IL 60525 708.352.3352
www.DrFimreite.com**

Fimreite Chiropractic
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

In the course of your care as a patient at Fimreite Chiropractic, we may need to use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer (if they are, or may be, responsible for the payment of your services).
- Your name, address, email, phone number, and your health care records may be used to contact you regarding appointment reminders or other appointment related issues, to provide information about alternatives to your present care or other health related information that may be of interest to you. Periodically, thank you letters, referral cards, newsletters, birthday cards, postcards, paper clippings or email messages may be sent.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or with another member of the household. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health insurance without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care, insurance forms or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and to protect the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to your privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

This notice is effective as of January 1, 2007. This notice, and any alterations or amendments made thereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

- Open adjusting rooms: we keep an open environment in the office to create a sense of warmth, family, healing and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member will speak with you about your condition or other matters in the closed private exam room.
- To Family and close friends involved in your care: Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness. If you object to the presence of your spouse or significant other at your report, please let us know immediately and we can refer you to another chiropractor.

In addition, we may disclose your Personal Health Information (PHI) to a family or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

- Requesting Restrictions: You have the right to request a restriction in how we use or disclose your PHI. However, we are not required to agree to your request. For instance, if you request that your spouse or significant other not be present when the doctor presents your report to you, we will not agree to such request.
- Right to inspect and copy: You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, PHI includes medical and billing records. To inspect and copy PHI, you must submit your request in writing on the form provided by our Practice. We will usually respond to your request within sixty (60) days. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

If we charge a fee, we will let you know the fee in writing, prior to making the copies, so that you can withdraw or modify your request before incurring a charge. In addition, we may charge to make copies of your record to send to another health care provider; if so, we will notify you in writing prior to making the copies.

We may deny your request to inspect and copy your PHI in certain circumstances. If you are denied access to your PHI, you may request that the denial be reviewed in certain circumstances. Another licensed health care professional chosen by the Practice will review your request and our denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

If you have a complaint regarding our privacy notice and/or our privacy practices, or would like further information about our privacy policies and practices please contact:

Gordon K. Fimreite, D.C.
4727 Willow Springs Road
La Grange, IL 60525
(708) 352-3325

Name (please print) _____ Signature _____ Date _____

If you are a minor or if another party is representing you:

Personal Representative Name (please print) Personal Representative Signature _____ Date _____

Description of the authority to act on behalf of the patient: _____