FINGER LAKES FAMILY CHIROPRACTIC & WELLNESS, P.C.
THE OFFICE OF DRS. MIKE AND MEREDITH VOROZILCHAK

Adult Intake Form

Name:____ Date:__________________

Address:____City / State / Zip:____________________

E-Mail:____ Date of Birth:_______________ Age:______

Home Phone:(___)________________Cell Phone:(___)________________Work Phone:(___)____________

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

Names / Ages of Children (if still part of your household):_______________________________

Occupation:_________________________________Employer:_____________________________

Emergency Contact:______________________ How they could be reached:_______________________

How did you hear about us? Whom may we thank for recommending you to our office?__________________

Tell Us About Your Goals For Care:

In general, what do you consider your overall health goals:

__ More energy
__ Improved performance
__ Illness prevention
__ Increased flexibility
__ Higher stress resistance
__ Better sleep
__ Stronger immunity
__ Easier breathing
__ Better posture
__ Slower aging
__ Improved mental clarity / focus
__ Increased relaxation / emotional well-being
__ Decreased reliance on medications
__ Improved digestion
__ Other:_____________________________

What results are hoping to experience by working with our office?____________________________

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How long do you anticipate it taking to reach these results?__________________________________

What do you feel is causing your health concerns?____

Have you ever been under chiropractic care in the past? Yes/No, With whom and when?_______________

Health History:

Please circle any symptoms or conditions you've experienced in the last 5 years:

Neck pain	Back pain	Sinus problems	Cancer	Insomnia	Carpal tunnel syndrome
Fibromyalgia	Acid reflux	Colitis / Crohn's / IBS	Hypertension	Osteoporosis	Depression / Anxiety
Headaches	Heart disease	Allergies / Asthma	Stroke	Diabetes	Chronic fatigue
Restless legs	Incontinence	Thyroid Imbalance	Sciatica	Other:_______________	

Please list any other diagnosed health conditions:_______________________________________

What medications do you take?____

What supplements do you take?____

Please list any surgeries you've had:____

Over the last 5 years, have your health, wellness, & quality of life: Decreased / Increased / Stayed the Same?

What other information about your health should we be aware of?____________________________

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

Signature:___________________________________ Date:_______________

Thank you for choosing our office! We look forward to serving you!

Office use only:

Notes:____

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Posture: RHF / LHF / RHT / LHT / AHT / RTT / LTT Dec ROM: RHR / LHR / RHF / LHF / CF / CE / RTR / LTR / RTF / LTF

Supine LLI: Left / Right Prone LLI: Left / Right Other Findings:_________________________

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Listings:____ Recc:___________________________