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

Pediatric Intake Form

Child's Name_____ Nickname _____Today's Date_____

Date of Birth_____ Age_____ Parent(s) Names _____

Address:_____City / State / Zip:_____

Parent's Home Phone:(___)_____Cell Phone:(___)_____Work Phone:(____)_____

Pediatrician:_____Other Health Providers: _____

Parent E-mail:_____ Preferred appt reminder: Text / E-mail / Neither

Tell Us About Your Goals For Care:

Which of the following best describe your child's overall health goals?

__Stronger Immunity __Better Sleep __Improved Digestion __Less Pain
__Injury Prevention __Improved Posture __Improved Concentration __Less Medications
__Improved Breathing __Other:_____

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

_____

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

What do you feel is causing your child's health concerns?_____

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

Health History:

Please list any diagnosed health conditions:_____

Please check any of the following that pertain your child:

__ Ear Infections __ Scoliosis __ Seizures __ Chronic Colds __ Asthma
__ Digestive Problems __ Allergies __ ADD /ADHD __ Recurrent Fevers __ Colic
__ Bed Wetting __ Headaches __ Growing Pains __ Motor Problems __ Neck Pain
__ Behavior Problems __ Trouble Sleeping __ Speech Difficulties __ Back Pain __ Autism Spectrum
__ Concussion(s) __ Whiplash __ Other:_____

What medications does your child take?_____

What supplements does your child take?_____

Please list any surgeries your child has had:_____

Please list any complications during pregnancy / labor / delivery:_____

Please list any injuries / accidents your child has had:_____

Has your child ever had adverse reaction to vaccinations? Yes/No, Describe:_____

What other information about your child's health should we be aware of?_____

_____

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

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

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

Office use only:

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:_____

_____

Listings:_____ Recc:_____