Welcome

Unit 106 - 8047, 199th street
Langley, BC, V2Y 0E2
Ph: 604-371-4320
Fx: 604-371-4323
Email: info@raichiropractic.ca
Web: www.raichiropractic.ca

Child personal information

First name ________________ Last name ________________ M / F

Birthday (M/D/Y) / / Age ____ Height ________ Weight ________ lbs / kgs

Does your child have any siblings? Y / N

How many? ______ What are their names and ages? ________________

Parent's / Guardian's Information

First name ________________ Last name ________________

Address ________________ Phone number Home ________________

________________ Cell ________________

City ________________ Postal code ________ Work ________________

Email ________________

May we communicate with you via email (for things like appointment reminders and important information)

□ YES □ NO

Marital status ________________ Occupation/s ________________

Emergency contact ________________ Relationship ________ Phone ________

How did you find us? (who can we thank for referring you?) ________________

care card number (MSP) ________________

We would like to know about your child's history

Has your child been under Chiropractic care before? Y / N If yes when? ________________

Breast fed Y / N Bottle fed (formula) Y / N ________________

Does your child drink Cow's milk? Y / N If yes, how much? ________________

Does your child have any food / juice allergies or intolerances? Y / N If yes, please list ________

> OVER

Has your child received any medication/s? Y / N If yes, please list all instances (including dose and duration)

> OVER

Has your child been involved in any high impact or serious falls? Y / N If yes, please list all instances

> OVER

Does your child play contact sports? Y / N If yes, please list ________________

> OVER

Has your child ever been involved in a car accident Y / N If yes, please describe ________ > OVER

Has your child ever been seen in the hospital emergency room? Y/ N If yes please describe ________

> OVER

Has your child experienced any of the following in the past 6 months?

Ear infections	O	Asthma	O	Seizure	O	Chronic colds	O
Headaches	O	Allergies	O	Digestive problems	O	ADHD	O
Recurring fevers	O	Growing/back pains	O	Colic	O	Bed wetting	O
Scoliosis	O	Temper tantrums	O	Other			

Vaccination history (which vaccinations and when) ____________________

____

____

____________________ > OVER

Has your child experienced any adverse effects following vaccination/s Y / N If yes, please describe ________

____

____

____________________ > OVER

ADMINISTRATIVE USE ONLY

Doctor has reviewed informed consent with patient INITIAL DATE

Rai Chiropractic

Specific concern

If you have a specific concern about your child's health

What is your concern? ____________________ > OVER

When did it begin (date)? ____________________

How did it begin? ____________________ > OVER

Does anything make it better? ____________________ > OVER

Does anything make it worse? ____________________ > OVER

Has your child's appetite been affected? If yes, please describe ____________________ > OVER

Has your child's sleep been affected? If yes, please describe ____________________ > OVER

Is your child crying excessively? If yes, how often? __________ Hours per day __________ Days per week

Is your child in pain? If yes, please describe ____________________

What is the severity of your child's pain? __________ 1-10 (1= virtually no pain / 10 = inconsolable)

Is there anything else you feel the Doctor should know? ____________________

Social Media Opt-Out Release Form

As a community chiropractic office, we like to share some of the exciting things happening in our office with our community via Facebook, Instagram and our Rai Chiropractic YouTube channel. If you or your child/ren would like to opt out of this please sign below.

I ________________________________ Patients Name ____________________________ Patients Signature

__________________________________ Child's Name (if under 18 years of age)

____

Signature of parent/guardian

I the above signed do not grant permission for Rai Chiropractic to use photos/video footage of myself and or my child/ren for social media.

Patient Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including X-rays if necessary, on me by the Doctor(s) of Chiropractic affiliated with me. I have had an opportunity to discuss with the doctor(s) of chiropractic, adjustments, and other procedures. Although I am expected to get great benefit from chiropractic care, I understand that the results are not guaranteed. I further understand and am informed that as in all health care, with certain chiropractic techniques, there are some very slight risks to treatment, including, but not limited to, muscle strains, and sprains, disc injuries and rib fractures. The possibility of an associated stroke with an upper cervical adjustment is extremely remote and un-established.

I do not expect the doctor to be able to anticipate all the risks and complications. I rely on the doctor's exercise of judgment which chiropractic procedure, based upon the facts known, is in my best interest. I have read this consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of current and future chiropractic care for which I seek treatment.

I understand that I am responsible for payment of all services and that they are to be paid in full at time service is rendered unless prior arrangements have been made.

Missed Appointment and Cancellation Policy

Missed appointments or those who do not inform us of an appointment cancellation 24 hours prior to appointment time will be charged a $55 fee. There is 24 hour / 7 day a week voicemail, text, and email for your convenience. Thank you.

Please only read this consent form, to familiarize yourself with it.

<u>You will sign it once you have had a chance to discuss it with the Doctor.</u>

Patient's Signature: ____ Date: ___________________

Parent/Guardian Signature: ________________________________Date: ___________________

Witness Signature: ____ Date: _____________________

(Doctor to Witness)