Rai Chiropractic

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

Infant / Toddler personal information

First name _____ Last name _____ M / F

Birthday (M/D/Y) / / Age _____ Length _____ cm / in 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 pregnancy

Did you carry to full term? Y / N If no then how long? _____

Were you under chiropractic care? Y / N If yes then how long? _____

Were you on any medications? Y / N If yes, please list with dose and duration _____

> OVER

How do you rate the quality of your nutrition during pregnancy? Excellent / Very good / Good / Fair / Poor

Did you have any cravings? Y / N If yes please describe _____ > OVER

How would you describe your physical activity during pregnancy? None / Mild / Moderate / Active / Very Active

Did you undertake any formal exercise? Y / N If yes please describe _____ > OVER

Were you under significant stress? Y / N If yes please describe _____ > OVER

Did you suffer severe nausea? Y / N If yes then when? Start _____ week End _____ week

ADMINISTRATIVE USE ONLY
Doctor has reviewed informed consent with patient INITIAL DATE

We would like to know about your delivery

Where did you give birth? _____

Were there any complications? Y / N If yes please list _____ > OVER

Did you receive any pain medication? Y / N If yes please list _____ > OVER

Were there any interventions? (please circle) Forceps / Vacuum extraction / C-section (emergency / planned)

If other then please describe _____ > OVER

Are there any genetic disorders or disabilities? _____

Birth weight _____ lbs Birth length _____ cms Birth head shape _____

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 If yes then when? start _____ week end _____ week

Bottle fed (breast milk) Y / N If yes then when? start _____ week end _____ week

Bottle fed (formula) Y / N If yes then when? start _____ week end _____ week

Cow's milk? Y / N If yes then when? _____ week Solids? Y / N If yes then when? _____ week

Does your child take probiotics? Y / N

How many bowel movements does your child have per day? _____

Does your child have any food / juice allergies or intolerances? Y / N If yes then please list _____ > OVER

Has your child received any medication/s or antibiotics? 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

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 suffered from any of the following conditions 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) _____

Has your child suffered any adverse effects following vaccination/s Y / N If yes please describe > OVER

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Specific concern

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

What is your concern? _____

When did it begin (date)? _____

How did it begin? _____

Does anything make it better? _____

Does anything make it worse? _____

Has your child's appetite been affected? If yes please describe _____

Has your child's sleep been affected? If yes please describe _____

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? _____

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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 $60 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.

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

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(Doctor to Witness)