Rai Chiropractic

Welcome

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

Personal Information

Last name _____ First name _____ M / F

I prefer to be called _____ Birthday (M/D/Y) / / Age _____

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 _____ Spouses Name _____

Children Y / N If yes, how many? _____ What are their names? _____

Your Occupation _____

We would like to know more about you

Height _____ Weight _____ lbs / kgs

What are your health goals?

☐ Hi - performance athletics ☐ Wellness and health ☐ Relief of pain and symptoms

Please expand on your health goals _____

_____

Physical activities you do during the week _____

_____

What are your hobbies? _____

_____

Avg. hours of sleep _____ hrs / night Consume caffeine Y / N Frequency _____ cups / day

Consume water Y/N _____ L / day

Is there any possibility you could be pregnant? Y / N Midwife Office: _____

How did you find us? (Who can we thank for referring you?) _____

Have you been under Chiropractic care before? Y / N If yes when? _____

Emergency contact _____ Relationship _____ Phone _____

Care card number (MSP) _____

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

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Injury / Concern

If your concern is due to injury or pain

Where is your concern located _____

When did it begin (date) _____

How did it begin _____

Does anything make it feel better _____

Does anything make it worse _____

Please describe your concern (aching, stabbing, numbness etc.) _____

_____

Does it radiate or refer to another part of your body Y / N Where? _____

What is the severity of your concern? _____ 1-10 (1= virtually no pain / 10 = worst pain imaginable)

What time of the (day / week) is your concern worst _____

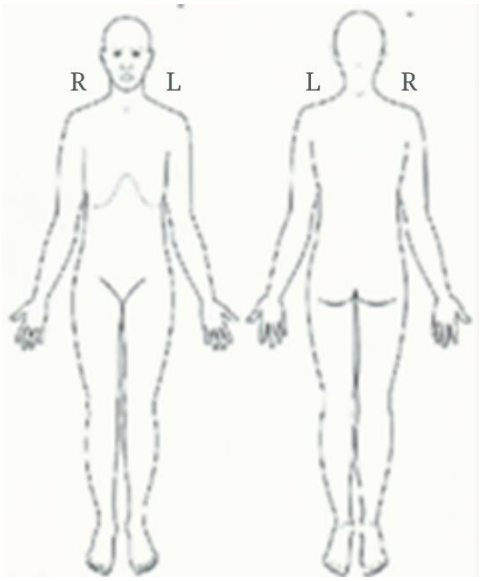
PRESENTING SYMPTOMS

Please show areas of pain or unusual feeling

Mark the areas of the body where you feel the described sensations

Include all affected areas

Numbness	N
Pins and needles	P
Burning	B
Aching	A
Stabbing	S



Health History

Have you ever suffered from? (please answer all questions)

Dizziness	Y / N	Constipation	Y / N
Heart trouble	Y / N	Diarrhea	Y / N
Diabetes	Y / N	Sinus trouble	Y / N
Arthritis	Y / N	Menstrual problems	Y / N
Headaches	Y / N	Cancer	Y / N
Migraines	Y / N	Chronic fatigue	Y / N
Asthma	Y / N	Sleeping difficulties	Y / N
Heart burn	Y / N	Depression	Y / N
Irritable bowels	Y / N	Ear noises	Y / N
Numbness	Y / N	Digestive problems	Y / N
Deafness	Y / N	High blood pressure	Y / N

Please list any operations (with dates) _____

Please list any illnesses (with dates) _____

Any other hospitalizations? _____

Please list any family health conditions (Arthritis, Diabetes, Cancer, Heart disease etc.) _____

_____

Have you ever smoked? (list amount, frequency and duration) _____

Medications currently taking _____

Period of time taking above medications _____

Have you ever been knocked unconscious? _____

How long unconscious? _____

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)