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

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? _____

Care card number (MSP) _____

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?) _____

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

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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? _____

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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.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(Doctor to Witness)