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| RaiChiropractic_Logo_Black.jpgDATE: | **Welcome** | Unit 106 - 8047, 199th streetLangley, BC, V2Y 0E2Ph: 604-371-4320Fx: 604-371-4323Email: info@raichiropractic.caWeb: www.raichiropractic.ca |
| **Child personal information** |
|  |
| First name |  | Last name |  | M / F |
|  |
| Birthday (M/D/Y) / / | Age |  | Does your child have any brothers and/or sisters? 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 |  |
|  |  |
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| --- |
| 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 then please list |  |
|  |
| > OVER |
|  |
| Has your child received any medication/s? Y / N | If yes then please list all instances (incl dose and duration) |
|  |
| > OVER |
|  |
| Has your child been involved in any high impact or serious falls? Y / N | If yes then please list all instances |
|  |
| > OVER |
|  |
| Does your child play contact sports? Y / N | If yes then 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 |
|  |

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| --- |
| Has your child experienced any of the following in the past 6 months? |
| Ear infectionsHeadachesRecurring feversScoliosis | ОООО | AsthmaAllergiesGrowing/back painsTemper tantrums | ОООО | SeizureDigestive problemsColic | ООО | Chronic coldsADHDBed wetting | ООО |
| Other |  |
|  |
| Vaccination history (which vaccinations and when) |  |
|  |
|  |
|  |
|  |
|  |
| > OVER |
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|  |
| Has your child experienced any adverse effects following vaccination/s | Y / N | If yes please describe |  |
|  |
|  |
|  |
|  |
| > OVER |

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| ADMINISTRATIVE USE ONLY |
| Doctor has reviewed informed consent with patient | INITIAL |  | DATE |  |
|  |  |  |  |  |
| RaiChiropractic_Logo_Black.jpg | **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.

 Please read this consent form and sign it once you have discussed it with the doctor.

 Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Doctor to Witness)