

CHILD INTAKE FORM

ABOUT THE PATIENT		DATE ____/____/____
Child's Name: _____		SS # ____-____-____
LAST	FIRST	MI
Date of Birth: ____/____/____	Age: ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address: _____		City: _____ State: _____ Zip: _____
Mother's Name: _____		Father's Name: _____
Home Phone: (____) ____-____	Work Phone: (____) ____-____	Cell Phone: (____) ____-____
Parent's email: _____		
Would you like to receive our newsletter/promotions? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Emergency Contact: _____		Relation: _____

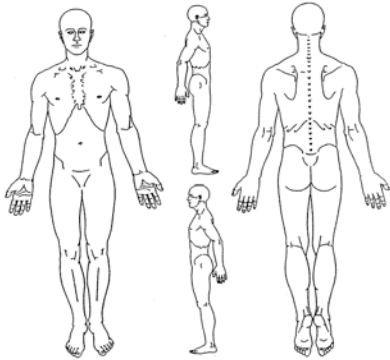
Whom may we thank for referring you? _____ How did you hear about us? _____

AUTHORIZATION FOR CARE OF A MINOR
Parent/Guardian Name: _____
I hereby authorize and consent to the chiropractic evaluation and care of my child
Parent/Guardian Signature: _____

INSURANCE / PAYMENT INFORMATION
Payment type: <input type="checkbox"/> Cash <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____
Insurance Company Name: _____ ID# _____ Group# _____

REASON FOR VISIT
<input type="checkbox"/> Wellness Check Up <input type="checkbox"/> Injury <input type="checkbox"/> Specific Concern: _____ When did you first notice problem: ____/____/____
How did it originally occur: _____
Have the symptoms progressed: <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse

Please Circle your area of main complaint



How frequent is the condition?

- Constant Frequently Intermittent Occasionally

Describe your symptoms: _____

- Sharp Dull Aching Burning Numbness Tingling Throbbing
 Stabbing OTHER _____

Does anything relieve the problem? If yes, please list - No Yes _____

Does anything make the problem worse? If yes, please list - No Yes _____

Does this condition interfere with: Work Family Daily Routine Sleep Sports
 OTHER: _____

Have you experienced this problem before? No Yes

Please Explain: _____

Have you sought treatment for this condition before? No Yes

Please Explain: _____

How do your symptoms currently feel?

0 1 2 3 4 5 6 7 8 9 10
 (No Pain) (Unbearable)

PREVIOUS TREATMENT	
Pediatrician: _____	Date of last visit: ____/____/____
Previous Chiropractic Care: <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____	Date of last visit: ____/____/____
OTHER: _____	
Previous Diagnosis: _____	LAST XRAYs Taken: ____/____/____



PAST MEDICAL HISTORY
Please mark any of the following that your child has currently or has had previously.

- Thumb sucking
- Diarrhea or constipation
- Irritable/temper problems
- Nightmares/sleep problems
- Number of meals each day _____
- Number of snacks _____
- Typical diet:

- Does your child take vitamins, fluoride, iron, or other supplements: _____
- Ever eaten dirt, paint, or plaster
- Child doesn't get along well with other children
- Problems with school/schoolwork
- Did mother smoke cigarettes, use alcohol or drugs, or any medications used during pregnancy: _____
- Toilet training problems
- Hearing problems
- Emotional disorders
- Dental problems
- Bed-wetting
- Eye problems
- Speech problems
- Discipline problems
- Epilepsy
- Developmental problems
- Mumps, Measles
- Chicken Pox
- Eczema/Skin problems
- Asthma/Wheezing
- Allergies
- Frequent colds or sore throats

- Frequent ear infections
- Colic as an infant
- Croup
- Pneumonia
- HIV/AIDS
- Abnormal bleeding
- Hemophilia
- Hepatitis
- Cancer
- Night Sweats
- TB/ Lung Disease
- High blood pressure
- Kidney/Bladder problems
- Sexually transmitted infection
- High cholesterol
- Handicaps/Disabilities
- Diabetes
- Rheumatic fever
- Congenital heart defect
- Heart murmur
- Broken bones: _____
- Major trauma, falls, or car accidents: _____
- Any evidence of birth trauma (bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other): _____
- Average # of TV hours/week: _____

- Delivery:
 - C-section
 - Vaginal
- Were forceps or vacuum extraction used during delivery? No Yes
- What gestation week was the child born: _____
- Were any of the following used throughout pregnancy:
 - Midwife
 - Doula
 - Chiropractor
- Was/Is the child breast-fed? No Yes
- Age discontinued breastfeeding: _____
- Has your child been vaccinated? No Yes
- If so, which ones and list reactions to them: _____
- Is your child currently on any medications? No Yes
- If so, please list: _____
- Is your child currently on any supplements? No Yes
- If so, please list: _____
- Has your child ever been on any antibiotics? No Yes
- How many courses: _____

AWARENESS OF RAK CHIROPRACTIC

- Did you know that the ADJUSTMENT directly influences your Nervous System? No Yes
- Did you also know that your Nervous System controls every function in YOUR Body? No Yes
- Are you aware the Dr. Katie is a certified pediatric, pre and postnatal chiropractor? No Yes
- Also, did you know she is Graston Technique Certified? No Yes
- Did you know that Dr. Katie played college basketball? No Yes
- Did know that infants should be adjusted from the moment they are born? No Yes Explain why: _____
- Did you know that one of original Dr. Mayo brothers took his wife to the founder of Chiropractic, Dr. BJ Palmer for Chiropractic Treatment? No Yes
- Are you aware that Dr. Ryley is certified in Active Release Technique, Graston Technique and Kinesio Taping? No Yes
- Did you know that Dr. Ryley was born and raised in Canada? No Yes
- Did you also know he attended 2 NHL Tryout Camps? No Yes
- Did you know the specialized treatments RAK CHIROPRACTIC provides, when combined with stretching education and therapeutic exercises are proven to reduce symptoms, restore proper biomechanics (through the CHIROPRACTIC ADJUSTMENT), improve flexibility and decrease the chance of recurrence, while improving sport performance? No Yes

Parent/ Guardian Signature: _____ Date: ____ / ____ / ____