CHILD INTAKE FORM

ABOUT THE PATIENT DATE_____/_____/_____

Child's Name: _____ SS # _____-_____-_____
LAST FIRST MI

Date of Birth: ____ / ____ / ____ Age: _____ Gender: ☐ Male ☐ 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? ☐ No ☐ 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: ☐ Cash ☐ Insurance ☐ Other:_____

Insurance Company Name: _____ ID# _____ Group# _____

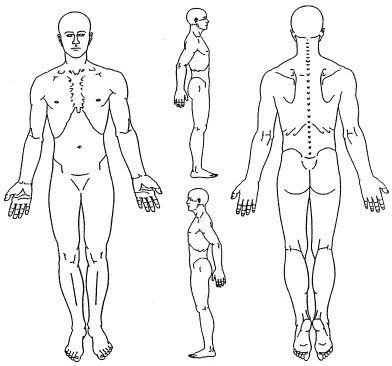
REASON FOR VISIT

Specific Concern:_____ When did you first notice problem: _____ / _____ / _____

How did it originally occur: _____

Have the symptoms progressed: ☐Same ☐Better ☐Worse

Please Circle your area of main complaint



How do your symptoms currently feel?

0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Unbearable)

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: _____

PREVIOUS TREATMENT

Pediatrician: _____ Date of last visit: _____ / _____ / _____

Previous Chiropractic Care: ☐No ☐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 ADJUSTEMENT 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 that 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

Patient Name:_____ Parent/ Guardian Signature:_____ Date: _____ / _____ / _____