Hello!

We are excited to meet you soon. Please mark your calendar.

Before your appointment with us, please fill out your Intake Form (the following pages). **If for some reason you do not get it filled out, please come 30 minutes early** so you have plenty of time to fill it out before your appointment with the Doctor.

During your first visit, you will have a complete chiropractic consultation and exam, with full spine x-rays (for people aged 4-5 and older) and computerized nerve scans. This is normally a fee of $260.00, but since you heard about us through a patient of ours or a flyer/coupon, it will be significantly discounted. ☺

You will want to allow between 30-40 minutes for your first visit.

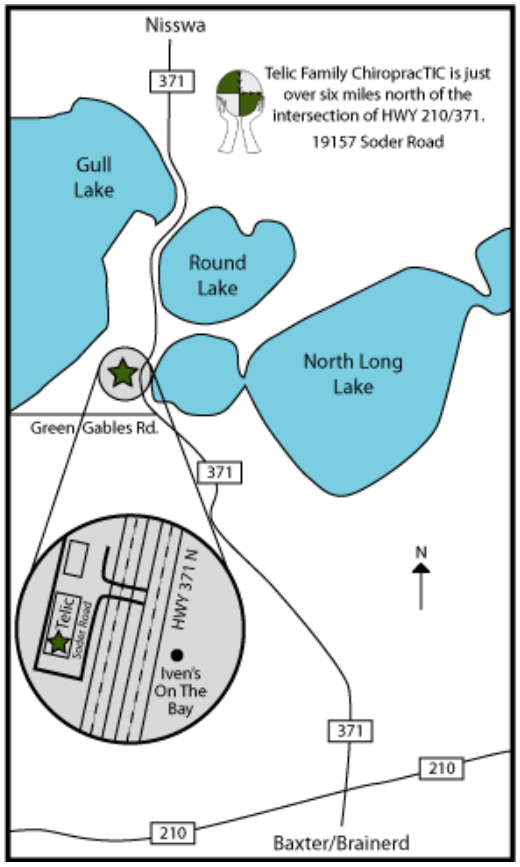
Need directions?

- Driving North, we are about 6 miles north of the intersection of Hwy 371 and Hwy 210. After you pass the Brainerd International Raceway, you will go about 1.5 miles and take a LEFT after you pass the intersection of Green Gables Road (right across from Ivan's on the Bay Restaurant).

- Driving South, after you pass the intersection of Ojibwa Park Road go about a mile and take a RIGHT after you see the road sign for Co Rd 126. We are across the highway from Ivan's on the Bay Restaurant.

We look forward to serving you and your family!

-Team Telic



We have over 750+ TESTIMONIALS from people up to 90 minutes from our Center (like St. Cloud, Wadena, Aitkin, Otter Tail, Sebeka and Walker - just to name a few). Be sure to check out our map and testimonial book when you get here!

"I have been able to **walk without pain** and stand straight again. I **sleep all night** and wake up rested...I have **not been sick for 3 years** since I began my care here." - Chuck age 63, Motley

"Since my adjustments started my **migraines, nerve pain and medications are gone.** I would recommend Dr. Andy to everyone. He not only adjusts you but also teaches everybody why their bodies behave the way they do." - Patty age 50, Aitkin

"We came to Dr. Andy for my son being **very colicky, gassy and suffered from stuffy nose.** He couldn't sleep well at all. It is so unbelievable to see my baby do "normal" baby things without crying...He now **sleeps 11 hours** at night without waking up every 20 minutes-1 hour." Rex age 6 months, Nisswa

About DR. ANDY

Dr. Andy Kuecher, DC, FICPA, SCP, DPhCS received his Doctorate of Chiropractic from Northwestern College of Chiropractic.

He has attained a 100-hour certification through the Gonstead Methodology Institute.

He is a Fellow of the International Chiropractic Pediatrics Association and has been thoroughly trained in the care of pregnant women and children.

He is also certified in the Webster technique for the care of pregnant women, newborns and children.

He has spoken at the International Chiropractors Association Council of Philosophical Standards in Fort Worth TX, Northwestern College of Chiropractic, and Palmer College of Chiropractic in Davenport IA. In addition, he has spoken at several local schools and hospitals on health and chiropracTIC.

He is a published chiropractic writer and contributing and co-author with Dr. Joseph Mercola in 101 Great Ways to Improve your Health and speaker on the topics of chiropracTIC and human potentiality.

His passion is chiropractic and the great outdoors.

Telic Family ChiropracTIC

CHILD INTAKE FORM

Welcome to Telic Family ChiropracTIC! We are excited you are here! Our center offers a unique service to individuals and families. We want to serve you to the best of our ability. Please be as thorough as possible when completing this form. As a family chiropractic center, we focus on your child's ability to be healthy.

ABOUT THE CHILD

Date____/____/____ Full Name_____

Nickname_____ ❑ Male ❑ Female Birth Date ____/____/____

Age_____ Height/Length_____ Weight_____

PARENT/ GUARDIAN'S INFORMATION

Full Name_____ Nickname_____

Address_____Apt #_____ City _____

State _____ Zip _____ ❑ Male ❑ Female Birth Date _____/_____/_____

Home Phone _____ Email Address _____

Social Security #_____ Drivers License #_____

Occupation_____ Work Phone_____

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse's Name_____ Spouse's Occupation_____

Names and ages of children _____

Emergency contact_____ Relationship _____Phone _____

Whom may we thank for referring you to our center?_____

OVERALL HEALTH PROFILE

Daily we all experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions to the best will give us information that will allow us to better assess any challenges to your child's health potential.

MOTHER'S PREGNANCY

Where there any complications to the pregnancy? ❑ Yes ❑ No If yes, explain _____

_____

Was Mom taking any medications, prescription or over-the-counter? ❑ Yes ❑ No If yes, explain _____

_____

Did Mom or Dad smoke during pregnancy? ❑ Yes ❑ No If yes, who?_____

Did Mom use alcohol during pregnancy? ❑ Yes ❑ No

Did Mom experience any illnesses during pregnancy? ❑ Yes ❑ No If yes, explain_____

Was the baby ever in the Breech position? ❑ Yes ❑ No ❑ Unsure

How many ultrasounds were performed? _____

LABOR, BIRTH AND DELIVERY

Where was the baby born? ❑ Home ❑ Hospital ❑ Birthing center ❑ Other _____

Was the delivery premature? ❑ Yes ❑ No If yes, at _____month and _____weight

Was the delivery: ❑ Vaginal ❑ C-section Were any devices used? ❑ Forceps ❑ Vacuum

Type of birth attendant: ❑ OBGYN ❑ Certified Nurse Midwife ❑ Lay Midwife ❑ Other; Name of Attendant_____

Was there any pulling or twisting on the baby's head? ❑ Yes ❑ No If so, by whom? _____

How long was the labor?_____ How long was the delivery?_____

Was the mother induced used? ❑ Yes ❑ No ❑ Unsure

Was an epidural /nerve block administered? ❑ Yes ❑ No ❑ Unsure

IMMEDIATELY FOLLOWING BIRTH

Check any of the following if the child experienced it immediately after birth: ❑ Jaundice ❑ Feeding problems ❑ Respiratory problems ❑ Displaced or broken bones ❑ Other condition(s) Explain_____

Approximately when was the umbilical cord cut? _____ min.

Was the baby slapped on the bottom to clear mucus? ❑ Yes ❑ No ❑ Unsure

Was the mother allowed to bond with the baby right after birth? ❑ Yes ❑ No If so, how long? _____

Was the baby bathed right after birth? ❑ Yes ❑ No ❑ Unsure

NEWBORN & INFANCY

Birth Weight _____ Birth Length _____ APGAR scores _____

Was the infant vaccinated? ❑ Yes ❑ No ❑ Unsure

Describe any and all reactions to vaccine(s) _____

Is/was there any prolonged use of medications? ❑ Yes ❑ No If yes, what? _____

Is/was the child breastfed? ❑ Yes ❑ No If yes, how long? _____ yrs _____ mo.

At what age was the child introduced to solids? _____ Cow's milk? _____

Did/has the infant suffer any traumas such as serious falls or car accidents? ❑ Yes ❑ No ❑ Unsure

Did/has the infant been under regular chiropractic care? ❑ Yes ❑ No

Number of hours sleeping per night: _____ Quality of sleep: ❑ Good ❑ Fair ❑ Poor

At what ages was the child able to: Respond to sound: _____ Respond to visual stimuli: _____ Sit up: _____ Hold head up: _____ Cross crawl: _____ Stand alone: _____ Walk alone: _____

CHILDHOOD YEARS

Approximately how many rounds of antibiotics has your child had? _____

Did the child have any major childhood illnesses? ❑ Yes ❑ No If yes, explain_____

Is the child accident prone? ❑ Yes ❑ No ❑ Unsure

Has/does the child play youth sports? ❑ Yes ❑ No If yes, which sport(s)? _____

Has the child ever broken any bones? ❑ Yes ❑ No If yes, explain_____

Has the child had any surgery(s)? ❑ Yes ❑ No If yes, explain_____

Has the child fallen from a height over 3 ft? ❑ Yes ❑ No If yes, explain_____

Has the child been hospitalized? ❑ Yes ❑ No If yes, explain _____

Please rate the child's diet: ❑ Poor ❑ Good ❑ Excellent

Was the child involved in any car accidents? ❑ Yes ❑ No If yes, when?_____

Has there been any prolonged use of medications? ❑ Yes ❑ No If yes, explain_____

Has the child suffered emotional traumas, such as parental divorce? ❑ Yes ❑ No

Does the child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No ❑ Unsure

ADDRESSING THE ISSUES THAT BRING YOU TO TELIC FAMILY CHIROPRACTIC

If the purpose of today's visit is a chiropractic subluxation check-up and you have no current health concerns, please check (✓) here ❑. If not, what is the reason for consulting our center?_____

Is this problem related to an Auto Accident? ❑ Yes ❑ No

How long has the child had this problem?_____

Has h/she had this problem before? ❑ Yes ❑ No ❑ Unsure

Has this problem: ❑ Gotten worse ❑ Stayed same ❑ Comes and goes

What seems to make this problem better?_____

What seems to make this problem worse?_____

Have you seen other doctors for this condition? ❑ Yes ❑ No

Chiropractor:_____Results:_____

Pediatrician / Medical Doctor:_____Results:_____

Other: _____Results:_____

Does this problem interfere with: ❑ Sleep ❑ Daily routine ❑ School ❑ Walking ❑ Sitting

❑ Hobbies ❑ Other activities _____

Explain _____

What changes (if any) would you like to see in the child's health and/or behavior? _____

_____

List any medications (either prescription or over the counter) the child is currently taking and for what reason:

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

BODY SIGNALS

Please **(✓)** all the conditions you are experiencing, even if they seem unrelated to the purpose of this visit.
Please put an **(✕)** you have previously experienced any of these conditions.

NMS:
- ❑ Neck pains
- ❑ Headaches
- ❑ Back pains
- ❑ Scoliosis
- ❑ Arm problems
- ❑ Joint problems
- ❑ Growing pains
- ❑ Stunted growth
- ❑ Paralysis
- ❑ Leg problems
- ❑ Muscle jerking
- ❑ Walking problems

Visceral:
- ❑ Skin problems / Eczema
- ❑ Pink eye
- ❑ Ear infections
- ❑ Tubes in the ears
- ❑ Allergies
- ❑ Sinus problems
- ❑ Frequent colds
- ❑ Breathing problems
- ❑ Upper respiratory infections
- ❑ Bronchitis
- ❑ Asthma
- ❑ Heart trouble
- ❑ Hypertension
- ❑ Digestive problems
- ❑ Stomach aches
- ❑ Food intolerances
- ❑ Juvenile diabetes
- ❑ Weight loss
- ❑ Loss of appetite
- ❑ Recurring fevers
- ❑ Anemia
- ❑ Constipation
- ❑ Diarrhea
- ❑ Bed wetting

Other:
- ❑ Sleeping disorders
- ❑ Insomnia
- ❑ Oversleeping
- ❑ Irritability
- ❑ Colic
- ❑ Hyperactivity
- ❑ ADD / ADHD
- ❑ Temper tantrums
- ❑ Depression
- ❑ Anxiety
- ❑ Low energy
- ❑ Mood swings

Special Senses:
- ❑ Vision problems
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Hearing impairment
- ❑ Epilepsy
- ❑ Seizures
- ❑ Other: _____

_____

CHIROPRACTIC EXPERIENCE

Have you or has anyone in your family ever seen a chiropractor? ❑ Yes ❑ No ❑ Unsure

If so, who and for what reason? Dr.'s Name _____Reason:_____

Approximate date of last visit: ____/____/____ Techniques/ Methods Used _____

Were the results: ❑ Poor ❑ Fair ❑ Good ❑ Very Good

Are you aware that the brain communicates with the rest of the body through the nerve system and controls everything your body including healing? ❑ Yes ❑ No

Are you aware that chiropractors work directly with the nerve system? ❑ Yes ❑ No

Do you know what a subluxation is? ❑ Yes ❑ No

Are you aware that when the bones of the spine are out of alignment, pressure is placed on the spinal cord and nerves? ❑ Yes ❑ No

Are you aware that research shows there are benefits from chiropractic care over the course of a lifetime? ❑ Yes ❑ No

What is your family's health philosophy (what should you do to be healthy)? _____

_____

Is there anything not included on this form that you feel the Doctor should know? _____

_____

The statements made on this form are accurate to the best of my recollection.

Parent / Guardian's signature: _____ Date: ____/____/____