Confidential Children's Health Questionnaire

Surname: _____ Given Names: _____

Parent Surname: _____ Parent Given Names: _____

Address: _____ Post code: _____

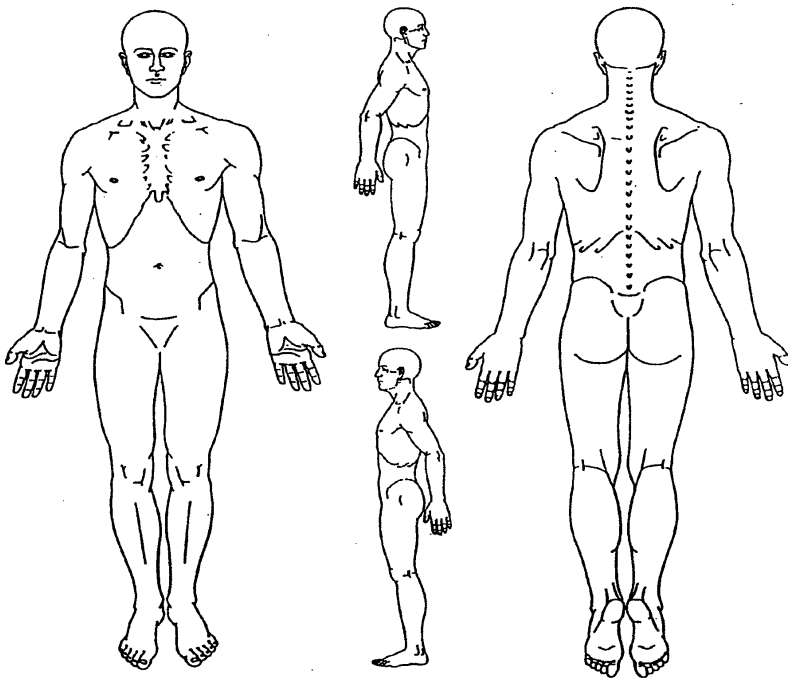
Telephone; Home: _____ Mobile: _____ DOB: ____/____/____ Age: _____

Parent Email: _____

Child Email: _____

Who can we thank for recommending you to us? _____

Please mark the entire area of your pain and problems on the diagram opposite.



Use the letters below to indicate the location and extent of your child's problems.

P – Pain	S – Stiffness
A – Ache	B – Burning
N – Numbness	W – Weakness
H – Heat	C - Cold sensations
T - Tingling	X – Other sensations

List the major complaints.

1. _____
2. _____
3. _____

Please list any other complaints or conditions.

1. _____
2. _____
3. _____

List *every* fall (swings, bicycles, learning to walk etc.), accident, motor vehicle accident, fracture or dislocation.

_____

_____

Please list *all* surgical procedures and year.

_____

What type of birth procedure? (Forceps, normal, caesarean) _____

How did the major condition start or happen?

_____

How long has the child had the major/main condition? Have they had this or similar in the past? When?

_____

Has the child received any treatment for the main complaint(s)? What type? _____

_____

Is your child on any medications or other drugs?

_____

Has your child ever been to a Chiropractor before? Who? When?

_____

Has your child ever been to a Naturopath before? When? Do they take any natural medicine, vitamins or herbs?

_____

Does your child drink soft drinks or coke? How much day/week? _____

Dietary – What would your child eat on a "normal" day?

Breakfast: _____

Morning Tea: _____

Lunch: _____

Afternoon Tea: _____

Dinner: _____

Supper: _____

Has your child experienced or had any of the following complaints or conditions?

Past – Present	Past – Present	Past – Present	Past – Present
General health			
❑ ❑ General fatigue	❑ ❑ Poor Appetite	❑ ❑ Rashes	❑ ❑ Chills
❑ ❑ Fever	❑ ❑ Night sweats	❑ ❑ Spontaneous sweating	❑ ❑ Unexplained weight loss
❑ ❑ Insomnia	❑ ❑ Poor sleep	❑ ❑ Irregular heart beats	❑ ❑ Blurred vision
❑ ❑ Ulcerations	❑ ❑ Itching	❑ ❑ Eczema	❑ ❑ Loss of hair
Head, Neck and Lungs			
❑ ❑ Migraine	❑ ❑ Flashing lights in eyes	❑ ❑ Nausea/vomiting	❑ ❑ Eye pain
❑ ❑ Headaches	❑ ❑ Earaches	❑ ❑ Ringing in ears	❑ ❑ Poor hearing
❑ ❑ Sinus or hay fever	❑ ❑ Nasal congestion	❑ ❑ Postnasal drip	❑ ❑ Recurrent ear infections
❑ ❑ Sore throat	❑ ❑ Dry throat	❑ ❑ Strong thirst	❑ ❑ Bitter taste in mouth
❑ ❑ Facial pain	❑ ❑ Teeth problems	❑ ❑ Grinding teeth	❑ ❑ Clicking jaw
❑ ❑ Recurrent cough	❑ ❑ Coughing blood	❑ ❑ Asthma	❑ ❑ Bronchitis
Musculoskeletal			
❑ ❑ Neck pain	❑ ❑ Pain between shoulders	❑ ❑ Mid-back pain	❑ ❑ Lower back pain
❑ ❑ Shoulder pain	❑ ❑ Elbow pain	❑ ❑ Wrist pain	❑ ❑ Finger pain
❑ ❑ Hip pain	❑ ❑ Knee pain	❑ ❑ Leg pains	❑ ❑ Ankle pain
Gastrointestinal			
❑ ❑ Nausea	❑ ❑ Vomiting	❑ ❑ Diarrhoea	❑ ❑ Constipation
❑ ❑ Indigestion	❑ ❑ Abdominal pains/cramps	❑ ❑ Blood in stools	❑ ❑ Rectal pain
Genitourinary			
❑ ❑ Pain on urination	❑ ❑ Frequent urination	❑ ❑ Blood in urine	❑ ❑ Kidney stones
❑ ❑ Bed-wetting	❑ ❑ Testicular pains	❑ ❑ Pelvic Pains	❑ ❑ Dribbling/burning urine

Consent to Chiropractic Care and Natural Medicine

When performed by a registered Doctor of Chiropractic, Spinal Corrections and manipulation are an effective and safe method of treatment for many conditions.

The use of Natural Medicine and natural therapies including Massage, Acupuncture and Naturopathy are also safe and effective for the treatment of many conditions. However, you must be informed about the rare risks involved as with all health care procedures.

These risks include: muscle and joint soreness or strains, nausea, vomiting, stomach upsets, infections, rashes, dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation of an underlying condition.

Careful attention to the questions below will help us to ensure that these risks are minimised and the appropriate treatment is provided.

Health Screening: Has your child ever been diagnosed, or experienced any of the following problems or conditions?

❑ Cancer	❑ Diabetes	❑ Heart disease/infection	❑ HIV or AIDS
❑ Asthma	❑ Arthritis	❑ Anaemia	❑ Required a heart pacemaker
❑ Stroke	❑ Hepatitis	❑ Blood disorders	❑ High Blood Pressure
❑ Epilepsy	❑ Collapsed lung	❑ Blood clotting problems	❑ Dizziness
❑ Pain waking child	❑ Pins & needles or numbness	❑ Pain on Coughing	❑ History of fainting or blackouts
❑ Knocked unconscious	❑ Pain with straining	❑ Pain on sneezing	❑ Any other serious illness

If yes, then please provide details:

_____

_____

_____

_____

If you have any further questions, please ask your practitioner during your consultation. You have the opportunity to discuss your proposed care with your practitioner and are encouraged to ask questions about the nature, extent and purpose of care that you need. You will have time to make an informed decision, giving consent for care to proceed.

I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed and I do not expect the practitioner to be able to anticipate all potential risks and possible complications associated with my proposed care.

I hereby acknowledge my consent to the performance of Chiropractic care, Rehabilitation, Massage, Acupuncture and Natural Medicine by my Practitioner.

Name of Child (print) _____

Name of Guardian (print) _____

Signature of Guardian _____ Date: _____

Practitioner _____ Date: _____