Confidential Children's Health Questionnaire

Surname: ______________________ Given Names: ______________________ Date: ___/___/___

Parent Surname: ____________________ Parent Given Names: __________________________

Parent Surname: ____________________ Parent Given Names: __________________________

Address: ______________________________ Suburb ________________ Post code: ________

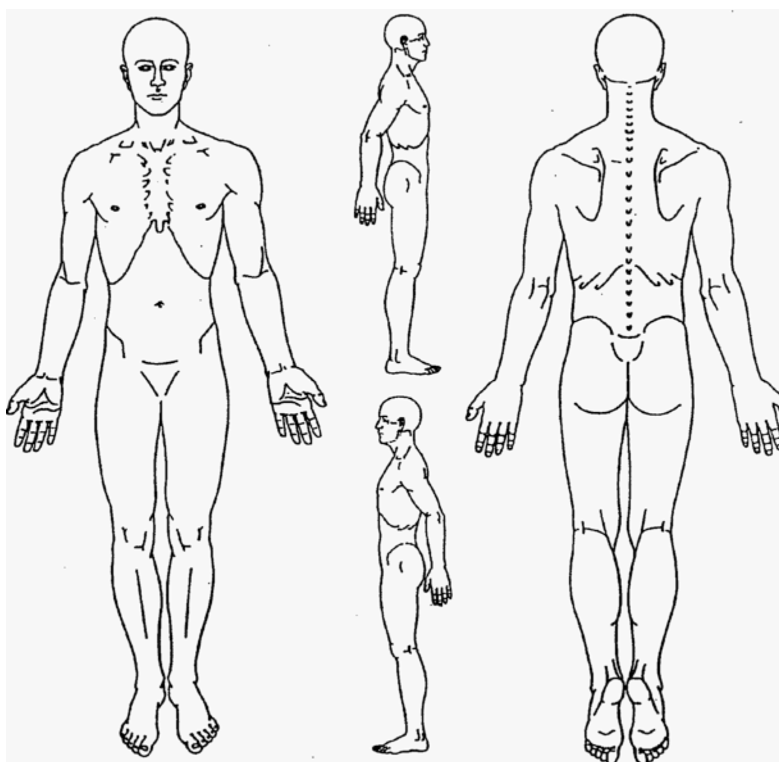
Telephone; Home: ________________ Mobile: ________________ DOB: ____/____/____ Age: ______

Email Address: ____

Who can we thank for recommending your child to us? ____________________________________

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

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



P – Pain　　S – Stiffness

N – Numbness　　B – Burning

H – Heat　　C - Cold sensations

T - Tingling　　Z – Other sensations

Please list your major complaints.

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YOUR PURPOSE

What would you like to achieve by coming to our clinic? (please tick)

Also, what would you like to achieve in general in your child's life? (please circle)

- ☐ Reduce pain
- ☐ Improve energy
- ☐ Nutrition
- ☐ Exercise
- ☐ Reduce anxiety
- ☐ Help with weight issues
- ☐ Improve general wellbeing
- ☐ Help with allergies
- ☐ Improve concentration
- ☐ Stress management
- ☐ Improve memory
- ☐ Emotional issues

Other: ____

How can we help your child?

❐Relief care – Symptomatic relief of pain or discomfort

❐Corrective care – Correcting and relieving the cause of the problem as well as the symptoms

❐Comprehensive care – Bring whatever is malfunctioning in the body to the highest state of health possible

❐I want the Doctor to select the type of care appropriate for my child's condition.

OUR PURPOSE

Our mission at Rennie Health Centres is to serve our patients and our community, providing quality service to each patient as a unique individual with specific health needs and wants. Our number one purpose is to serve you.We believe the more information a person has about their state of being, the more they are able to make a positive decision, one that affects their whole body & health for the betterment of themselves and their loved ones.
Our aim is to help You reach your optimal health and well-being, feel energised, achieve vitality by understanding your body through the wonderful healing nature of chiropractic and other complementary therapies.

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

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Please list *all* surgical procedures and year.

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

How did the major condition start or happen?

____

How long has your child had their 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?

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Does your child drink energy drinks, 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?

(Please tick the first box for past occurrence, second box for present condition.)

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

Changes to the law now require all practitioners who adjust the spine to warn clients of material risks.

In extremely rare circumstances, chiropractic care of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx. 1 in 5,850,000 neck adjustments). While this has never occurred in this office, we are still required to warn you. If any adjustments are required, you will be tested beforehand, as has always been our practice (i.e. check for dizziness, referred pain etc.)

Other than slight risks including strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000), chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with spine related problems than medication and many other alternatives.

When performed by a registered Chiropractor, manipulation is an effective and safe method of treatment for 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: Have you 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
❐ Knocked unconscious	❐ Pain with straining	❐ Pain on sneezing	❐ Any other serious illness

If yes, then please provide details:

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If you have any further questions, please ask your child's practitioner during his/her consultation. You have the opportunity to discuss your child's proposed care with his/her practitioner and are encouraged to ask questions about the nature, extent and purpose of care that your child needs, and given time to make a decision giving consent for the 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 child's proposed care.

I hereby acknowledge my consent to the performance of Chiropractic care, Massage and Natural Medicine by my child's Practitioner.

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Guardian's Name (Print)

______________________________	______________________________
Guardian's Signature	Chiropractor's Signature
______________________________	______________________________
Date	Date