New Patient Health Questionnaire (Age 5-18)

Thank you for choosing Spinewaves for your child's chiropractic care. Please complete the form in ink. The information you provide here will help us in understanding their condition and preparing their file. For us to decide whether their problem is suitable for chiropractic, we are required to assess all aspects of their current state of health. If you require help at any stage please ask, we are happy to help.

The files held at this clinic are STRICTLY CONFIDENTIAL.

Child's Name: …………………………………..…………………………….. Date of Birth: …….….…………………

Mother's Name: ………………………………………Father's Name: …………..…………………………………..

Address: ………………………..………………………………………………………..…………..…………………………...

……………………………..…………………………...…………….. Post Code……………………………………

Tel (Home): …….…….…..……..…..… Tel (Work): ………..……………….… Tel (Mobile): ……………………...……..

E-Mail:………………….………………………….......... GP Name & Address……………………….……………

☐ **Please tick if you DO want newsletters / health tips / advice**

Do you have any health insurance? Yes No Which company...

How did you hear about Chiropractic / this clinic? GP Health Visitor Friend/Family

Internet search Our website Advert Other: ………………………………………………

Reason(s) for consulting us:
………………………………………………………..…………………………..……………..…………………………………...

Have you consulted anyone else?: …….………………….……………………………..……..……………………………....

Is your child on any medication? ………………………………………………………………………………….........

Has your child had any medical treatment / scans / x-rays / surgery?: ……….…….……………………………………..

Was your child born with any congenital disorder?: ………………………………………………….……………………

Has your child had any vaccinations?....................................Any reactions?:...

Has your child had any childhood illnesses?...

Any known allergies?: …………………………………………………………………………………………………

Does your child have a good diet? ………………………………………………………………………………….

Which sports activities does your child do? ……………………………………………………………………………..

Regular bowel movements?: …………..………………………Does your child sleep well? Yes No

Physical development (i.e. weight gain, height gain, etc) …………………………………………………………….

Has your child had any significant falls/ accidents?……………………………………………………………………

Has your child broken/fractured any bones?..

Has your child had any antibiotics? …………………………………………………………………………………

Has your child had any other prescription medication? ……………………………………………………………

Does your child have any vitamin or mineral supplements? ………………………………………………………

How would you describe your child's emotional/mental health? ……………………………………………………

How would you describe your child's activity level? …………………………………………………………………

Family history of medical problems?.....

Number & ages of siblings.....

OTHER PROBLEMS: Is or has your child ever experienced (Please circle):

Constipation	Diarrhoea	Hyperactivity	Attention issues	Diagnosed with ADHD
Concentration issues	Learning difficulties	Behavioural problems	Balance or coordination issues	Diagnosed with Autistic Spectrum Disorder
Recurrent colds	Ear aches	Asthma	Scoliosis	Growing Pains
Headaches	Back pain	Neck pain	Sinus problems	Bedwetting
Night Terrors	Joint problems	Clicky hip	Convulsions	Tonsillitis
Chronic fatigue	Food intolerances	Food Dislikes/Issues with foods		

Any other information you think might be relevant? ……

PRENATAL / BIRTH

Any maternal illness or medical treatment during pregnancy?: ……

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Did your child follow his/her Milestones:
Tick if achieved / cross if not achieved

7-9 months - sitting unaided…… 9-12 months - standing unsupported……..

Did your child bum-shuffle? Yes No

11 months – crawling …….. 14 months - walks unaided……..

2 years – speech……. 3 years – self dressing……..

Data Protection Policy

Under the General Data Protection Rules (2018), as a health service provider, we are required to advise our patient(s) on our Data Protection Policy for the purpose of consultation, examination and treatment. As part of the patient record, the clinic is required to retain information for the purpose of consultation for treatment, recording subsequent treatments, and for use by third party medical practitioners only, at the request of the patient, in writing. Information will be held both manually and electronically in files accessible only by staff of the Clinic who are directly involved in the data entry and processing of patient records. Information will be kept for as long as the patient remains a patient of the Clinic, and thereafter for a period of 8 years (or age 25 if longer), after which the patient has the right for their data to be erased, providing there is no overriding legal reason. All information provided will be treated as confidential, and will not be given to any other person(s)/organizations(s) without the explicit consent of the patient concerned. With the exception of Employees, Partners and Owners of the practice. Our full Privacy Policy is available in the clinic patient information folder and can be found on our website: **www.spinewaves.co.uk/info/privacy**

Informed Consent to Treatment - To be completed after Examination and Review of Findings

- ☐ **I have received a full explanation of my child's condition including Differential diagnosis**
- ☐ **I have had the opportunity to ask questions**
- ☐ **I have been advised of care options and the likely benefits.**
- ☐ **I understand that reassessments and reviews will be performed at 6-12 visit intervals**
- ☐ **I have been advised of possible side effects and risks associated with treatment**

I the authorised Guardian, **understand** my child's condition and the proposed care plan as it has been explained to me. **I agree** to the procedure(s) and/or course of chiropractic care as described. I have been made aware and understand the clinic data policy.

Parent's Signature	**Name (PRINT)**	**Date**