loving life chiropractic

"A Better Way To Family Health"

Loving Life Chiropractic - U16 Questionnaire

Welcome to Loving Life Chiropractic. We intend to give you/your child the very best service possible and in order to do so we need further information. This form is to be filled out by a parent or guardian for all under 16 years.
At Loving Life Chiropractic we do not diagnose or treat symptoms, disease or illness but we are concerned with restored function in the nervous system and balance in the spine. We achieve this by correcting interferences in the spine and nervous system called VERTEBRAL SUBLUXATIONS. All information is treated in the strictest confidence.

U16 Details **Date: / /20**

Male/Female_____ First names: _____ Surname:_____ Birthday/Age:_____/___

Parent/Guardian Details

Full Name: _____ Relationship _____ Are you currently under care? Y / N

Address:_____ Post Town: _____ Post Code: _____

Home Phone:_____Work Phone:_____Mobile Phone: _____

E mail: _____

Occupation: _____Business Address_____

Spouse/Partner's name: _____ Marital status _____ No of Dependent Children: _____ Aqes:_____

How did you hear about our practice?

☐ Referred by someone (please specify)_____ ☐ newspaper ☐ GP/health specialist

☐ Outreach/event ☐ Google ☐ signage ☐ Other (please specify) _____

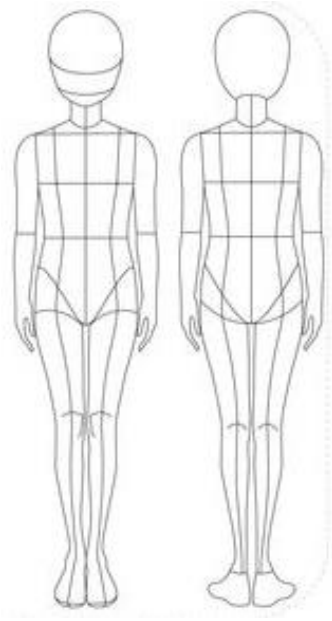
What is the main reason for your child attending this office?

☐ A desire to improve overall wellbeing ☐ A concern about a specific symptom/health challenge

What do you feel is your child's main symptom/health challenge? _____

How did this problem start? _____

Have there been similar problems in the past? _____



Has it recently ☐ got worse ☐ stayed the same☐ started and stopped

Who else (Chiro/GP/Physio etc) have you seen for this specific health challenge?

_____When? _____

Results_____

If your child has a GP what is their name/address?_____

On the diagram indicate any areas of discomfort. Use the legend to help describe the sensation. Sharp pain = #### Dull ache = XXXX Numbness and Tingling OOO.

With improved Quality of Life what would like your child to be able to do?
e.g. go for walks without getting coughing fits, sleep all night through, concentrate better

_____

Mark on the line how you would rate your child's **CURRENT HEALTH** in general**.**

☹↓ _____ ↓☺

1 2 3 4 5 6 7 8 9 10

Poor Health Excellent Health

Why do you feel they are at this health level :_____ _____

From 1 -10 how committed are you to resolving these issues**?**

↓ _____↓☺

1 2 3 4 5 6 7 8 9 10

No commitment Fully Committed

History of Child's Health Challenges/Symptoms

This is your opportunity to tell us about **all** your child's health challenges, past and present, **whether you believe they are connected to the current main health challenge or not**. The Chiropractic Doctor will use this information to: a. determine the best approach to restoring nervous system and spinal balance b. gauge the level of returning nervous system function. Tick all conditions applicable to you **and please provide further details in the table that follows:**

General
- ☐ Allergies
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headaches
- ☐ Loss of sleep/insomnia
- ☐ Loss of weight
- ☐ Anxiety/depression
- ☐ Numbness
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Hyperactivity

Muscle & Joint
- ☐ Arthritis
- ☐ Hernia
- ☐ Low back pain
- ☐ Neck pain
- ☐ Pain between shoulders

Numbness and pain in
- ☐ Shoulders
- ☐ Upper arms
- ☐ Hands
- ☐ Legs
- ☐ Feet
- ☐ Pins and needles
- ☐ Poor posture
- ☐ Swollen joints
- ☐ Gout
- ☐ Polio

Gastro-Intestinal
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Digestive dysfunction
- ☐ Gall bladder trouble
- ☐ Haemorrhoids
- ☐ Liver trouble
- ☐ Ulcers

Eyes, Ears, Nose and Throat
- ☐ Frequent colds
- ☐ Crossed eyes
- ☐ Short/long sighted
- ☐ Deafness
- ☐ Ear infections
- ☐ Ringing in ears
- ☐ Eye pain
- ☐ Vision obstruction
- ☐ Sinus infection

Cardio Vascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Irregular heart beat
- ☐ Ankle swelling
- ☐ Anaemia
- ☐ Arteriosclerosis
- ☐ Stroke

Respiratory
- ☐ Asthma
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Breathing problems
- ☐ Wheezing
- ☐ Emphysema

Genito-Urinary
- ☐ Bed-wetting
- ☐ Painful Urination
- ☐ Prostate trouble
- ☐ Blood in urine
- ☐ Veneral disease

Female Only
- ☐ Menstrual cramps
- ☐ Excess menstrtn
- ☐ Irregular cycle
- ☐ Hot flushes
- ☐ Currently pregnant

☐ **OTHER (please detail in table)**

Please give further details of all conditions ticked above:

Health Challenge/Symptom	Date First Noticed	Any event linked to onset?	How does/did it affect Quality of Life?	Current frequency, constant, or date ceased?	Other Remarks

Sources of Spinal Stress/Nervous System Trauma Vertebral Subluxations are caused by stress. There are 3 main stresses in Life – **Physical, Chemical and Emotional**. On the following pages please indicate sources of stress most relevant to your child:

PHYSICAL STRESS

Trauma

- ☐ Falls as infant
- ☐ Falls as child
- ☐ Sports trauma
- ☐ Broken bones
- ☐ Physical Fight
- ☐ Repetitive Stress Injury
- ☐ Other _____

Primary Daily Activities

- ☐ Playing outside
- ☐ Playing inside
- ☐ Walking
- ☐ Sat at Computer
- ☐ Watching
- ☐ In cot

Was their birth:

- ☐ At home
- ☐ Premature
- ☐ Breech
- ☐ Forceps
- ☐ Vacuum Extraction
- ☐ Epidural
- ☐ Prolonged delivery
- ☐ Pulling in delivery
- ☐ Drug induced
- ☐ Cord around neck
- ☐ Gas and air
- ☐ C-Section
- ☐ Unassisted/Natural
- ☐ **UNSURE**

Please detail any motor vehicle accidents your child has been in, even if at low speed or if they walked away unharmed (e.g. rear end, 30mph, hospital, 2 years ago)

_____

_____

Details of other accidents or traumas:

_____

_____

Surgery

Have they had surgery such as:

☐ Tonsils ☐ Appendix ☐ Tubes/Ear Op ☐ Spinal/Disc ☐ Endoscopy

☐ Heart surgery ☐ Trauma Repair ☐ Other _____

CHEMICAL STRESSES

Medication

Please detail any medication they are taking-over the counter, as well as prescribed. Continue on separate sheet if necessary

Name Dose What for?

_____

_____

_____

Vitamins/Supplements

Indicate any vitamins or supplements they take_____

Other Habits (please indicate quantities)

Glasses water/day	Coffee & Tea cups/day	Cigarettes/day	Alcohol Units/week	Fizzy Pop glasses/day
☐ 0	☐ 0	☐ 0	☐ 0 (1 pint = 2 units)	☐ 0
☐ 1-2	☐ 1-2	☐ 1 -10	☐ 1 - 5	☐ 1-2
☐ 3-5	☐ 3-5	☐ 10+	☐ 5 -20	☐ 3-5
☐ 5+	☐ 5+	☐ Ex-smoker	☐ 20+	☐ 5+

Sleep hours/day	Exercise/week	Fresh Fruit/day	Fresh Vegetables	Processed/Ready Meals
☐ less than 4	☐ None	☐ None	☐ None	☐ None
☐ 4-6	☐ 1-3 times	☐ 1 piece	☐ Daily	☐ Once a week
☐ 6-8	☐ 3-6 times	☐ 2-5 pieces	☐ 2 x Daily	☐ Daily
☐ **8+**	☐ 6+ times	☐ 5+ pieces	☐ 3 x Daily	☐ 2+ a day

Do they eat/drink: ☐ diet products ☐ dairy products ☐ meat products ☐ fish ☐ vegetarian/vegan only ☐ sugary foods

What type of exercise/activity do they most enjoy? _____

Do they sleep on their stomach? ☐ yes ☐ no

Were they vaccinated as a child? ☐ yes ☐ no If YES do you recall any reactions/illness in the first 3-6 months after the vaccination? ☐ yes ☐ no If YES please give details _____

Did you know you can opt out of vaccinations if you choose to? ☐ yes ☐ no

EMOTIONAL STRESS (e.g. new school, family problems, exam stress, house move)

What degree of emotional stress is your child under:

In the Past	☐ None	☐ Light	☐Moderate	☐ Heavy
At Present	☐ None	☐ Light	☐Moderate	☐ Heavy

THANKS FOR COMPLETING THIS QUESTIONNAIRE ON BEHALF OF YOUR CHILD.

PLEASE CAREFULLY READ AND SIGN THE FOLLOWING POLICY AND CONSENT DOCUMENT

Practice Policy

In this office we practice the first Principles of Chiropractic and as such we aim to identify the cause of poorly expressed health due to interference in the nervous system at the level of the spine. These interferences are called ”Vertebral Subluxations”.

At Loving LIFE Chiropractic we do not diagnose or treat symptoms, disease or illness but we are concerned with the restoration of your health potential. Once your body returns to a state of balance (homeostasis) it can deal much more readily with any health challenges.

1. A recommended schedule of care will be outlined which is aimed at correcting vertebral subluxations and improving your child’s nervous system and spinal health within a reasonable time period and we strongly recommend that this schedule is adhered to. If there is a need to reschedule appointments we will do so as close to the original appointment in order to maintain momentum in your healing processes. **If you fail to attend an appointment or reschedule without giving at least 12 hour notice then you give us permission to charge the usual fee.**
2. The normal visits will be conducted in our open room. If you wish to discuss something of a confidential nature outside of the regular Progress Exams please make an appointment at the front desk for a Private Visit.
3. Your documents and notes are treated in the strictest confidence and will not be discussed or released to any person (e.g. lawyer or insurance official) without your written consent.
4. If you believe any aspect of your care in our practice can be improved please tell us immediately. We are here to serve you and we are happy to receive feedback, both positive and negative.
5. Children are more than welcome in this Family Practice and whilst we aim to provide as safe an environment as possible their safety and behaviour remains your responsibility.

Please sign here to indicate you have read and understand the practice policy.

Signature _____ Date _____

Chiropractic Care Consent

Chiropractic has established a reputation for providing excellent results in the promotion of good health and well being through the improvement of nervous system and spinal function. Everyone is individual and unfortunately no guarantees can be offered.

Ethically, before starting your care we need you to be informed of any risks so please read the following carefully.

Occasionally people under care experience mild healing effects and reactions such as muscle stiffness, local tenderness, tiredness, headaches, "flu-type" symptoms, release of emotions (such as crying) or dizziness. On very rare occasions 1 in 10,000 people report rib fracture. Whilst often reported anecdotally, serious injuries such as stroke are so extremely rare that they are reported as being less than 1 stroke per 2 Million cervical adjustments. To put this into perspective hospitalisations as a result of, one of the mildest medical interventions such as, taking anti-inflammatory medications (e.g. Ibuprofen™) are estimated at 40,000 per Million (i.e. 80,000 times more likely) and deaths at 4000 per Million (i.e. 8,000 times more likely) respectively.

There are no definite tests to indicate the risks to an individual, however extensive, prolonged, studies show that qualified, well-trained chiropractors provide an extremely safe form of care.

I give consent for my child to receive a chiropractic assessment which may includes a non-intrusive Spinal Scan and a full hands-on examination at this practice. When deemed appropriate by the Chiropractic Doctor I consent to receiving a chiropractic adjustment.

Signed:_____Date:_____

If under 16 years old,

I,_____consent for :_____to receive chiropractic care

Signature of parent/guardian:_____Date:_____

Relationship:_____