*Welcome to the family*

OMEGA® Chiropractic & Radiology

**CONFIDENTIAL HEALTH AND WELLNESS QUESTIONNAIRE**

Our team believes that health is more than just how you feel. True health and wellness means you and your child are physically, mentally and emotionally at your best.

**ABOUT YOUR CHILD**

Full name _____ Date _____

Date of birth: _____ Gender: M / F

Mum's name: _____

Dad's name _____

Siblings names and ages: _____

Address _____

_____ Postcode _____

Telephone H _____ W _____ M _____

Email _____

Who may we thank for referring you?_____

**GENERAL HEALTH HISTORY**

Has your child had any major accidents, injuries or illnesses in the past? _____

_____

Has your child ever been hospitalised? What for? _____

_____

What medications has your child taken in the past? (Antibiotics etc.) _____

_____

Have your child ever seen a chiropractor before?_____

**YOUR CHILDS' CURRENT HEALTH**

Please tick any of the following symptoms your child has experienced:

| | | |
|---|---|---|
| □ Poor concentration | □ Allergies / Sinus | □ Reflux |
| □ Learning difficulties | □ Digestive problems | □ Epilepsy / Seizures |
| □ ADHD /Autism /Hyperactivity | □ Irritability / Moodiness | □ Numbness/tingling in arms/hands |
| □ Bed wetting | □ Depression / Nervousness | □ Dizziness / Ringing in the ears |
| □ Recurrent colds/Flu | □ Fatigue / Energy levels | □ Pain between shoulders |
| □ Low immunity | □ Weight problems | □ Numbness / tingling in legs / feet |
| □ Asthma / Breathing problems | □ Headaches / Migraines | □ Hip pain |
| □ Constipation / Diarrhoea | □ Ear infections (Left / Right) | □ Bowel / Bladder problems |
| □ Poor sleeping patterns | □ Leg pain / Cramps | □Poor posture |
| □ Growing Pains | | |

What is the main reason you have brought your child to see us? _____

How long has child had this problem? _____

How did this problem start? _____

What makes this problem better? _____

What makes this problem worse? _____

Have you sought any treatment for this/these issues? _____

**LIFESTYLE:**

What does your child like doing? _____

How much screen time does your child have a day? _____

**INFORMED CONSENT**

I consent to a professional and complete chiropractic examination and any care the chiropractor deems necessary for my child. I consent for their information being shared within the practice.

Print your name: _____

Signature: _____