

Children's Questionnaire

CHILD'S NAME

MALE/FEMALE

DATE OF BIRTH

AGE NOW

BIRTH WEIGHT

WEIGHT NOW

NAMES AND AGES OF SIBLING/S

NAME OF PARENT / GUARDIAN

ADDRESS

TEL NO (Home)

PARENT'S (Work)

GP's NAME

ADDRESS

TEL NO

IS THERE ANY SPECIAL REASON WHY YOU ARE BRINGING YOUR CHILD/BABY?

PREGNANCY & BIRTH

QUESTIONS ABOUT THE MOTHER

WHAT WAS YOUR AGE DURING THIS PREGNANCY

DID YOU HAVE ANY PROBLEMS

DID YOU TAKE ANY MEDICATION

WHAT TESTS DID YOU HAVE (Eg Ultrasound, amniocentesis etc.)

DELIVERY

WAS YOUR BABY BORN ON THE DUE DATE

WAS THE DELIVERY AS YOU HAD HOPED

WHEN DID THE CONTRACTIONS START

WHEN DID THE WATERS BREAK

WHEN WAS THE BABY BORN

DESCRIBE BRIEFLY IN YOUR OWN WORDS THE DELIVERY AND BIRTH

(Include anything you think is significant or important, please include details of any pain relief, forceps/vacuum pump etc)

SLEEPING

ANY PROBLEMS SLEEPING

MEDICAL HISTORY

VACCINATIONS (Delete as applicable)

DIPHTHERIA/POLIO/TETANUS/HIB (meningitis)/WHOOPIING COUGH/MMR

ANY PROBLEMS FOLLOWING VACCINATIONS

ALLERGIES.

ILLNESSES (Including medication if you know it)

HOSPITAL ADMISSIONS (Casualty/tests/treatments/operations)

MEDICATION (What drugs or medication is your child taking now)

ACCIDENTS

DENTAL HISTORY (Any problems with treatment/orthodontics?)

HAS THE CHILD SEEN A CHIROPODIST (Were orthotics prescribed?)

FAMILY HISTORY

PARENTS (Any history of illness/allergy/flat feet/knee, hip or spinal deformity or back pain)

BROTHERS AND SISTERS (Birth weights/any health problems/similarities or differences to the patient)

FAMILY GENERAL HEALTH (Parents/grandparents/aunts & uncles)

The Data Protection Act ("the Act") lays down certain requirements for protection against unauthorised disclosure of personal information. The Act also gives you certain rights. In order that we may use the personal information for the purposes of providing osteopathic and/or any relevant treatment, we are required by the act to obtain your written consent.

Accordingly, we would be obliged if you would sign the consent section below.

I CONSENT TO THE USE OF MY CHILD'S PERSONAL INFORMATION FOR THE PURPOSES SET OUT ABOVE.

I CONFIRM THAT THE INFORMATION I HAVE PROVIDED IN THIS FORM, AND DURING THE COURSE OF MY CHILD'S TREATMENT IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AND COMPLETE.

Signature of Parent or Guardian.

Date.

DO YOU HAVE ANY OBJECTION TO YOUR DOCTOR BEING INFORMED THAT YOUR CHILD IS RECEIVING OSTEOPATHIC TREATMENT. YES/NO.

Thank you.

CHILDREN'S



QUESTIONNAIRE

Before you bring your child to see us it would be most helpful if you would complete the following questionnaire and bring it with you to your first appointment. This will enable us to make the best use of the time available, as well as enabling us to avoid subjects that you may not wish discussed in front of your child. .

The information which you provide in this form, and any other relevant information obtained during the course of treatment is on a strictly confidential basis.

This information will be used solely for the purposes of providing osteopathic and/or any related treatment. We will not disclose any personal information we hold about you outside the practice without your explicit consent, except to the extent we are required or permitted by law.