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?_____

YOUR CHILDS BIRTH:

How many weeks pregnant were you when you gave birth? _____

Were you induced? Y / N Did you have an epidural? Y / N Did you have a caesarean Y / N

Was there any pulling on child's head? Y / N

Were there any complications during the birth or after for child or yourself? _____

_____

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? _____

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?_____

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: _____