Health Questionnaire

Name _____ D.O.B. _____

Parent's Name _____Phone _____

Email Address _____

Please write in your own words your child's main complaint: _____
_____
_____

Questions Regarding Birth

Was the birth chemically induced? Yes/No
Was a C-section performed? Yes/No
Were forceps/vacuum used? Yes/No
Were mother and child separated? Yes/No
Infant breastfed? Yes/No
Any other important notes regarding the birth? _____
_____
_____

Please check any symptoms your child has had in the past 6 months

___ Dizziness/Vertigo
___ Headaches
___ Loss of Hearing
___ Ear/Throat Infections
___ Bloody Noses
___ Sinus Problems
___ Cold/Flu
___ Sleep Issues
___ Neck Pain
___ Food Sensitivities
___ Milk/Lactose Intolerance
___ Breathing Problems
___ Asthma/Allergies
___ Bed Wetting
___ Constipation
___ Diarrhoea
___ Low Back Pain
___ Anxiety
___ Irritability
___ Rashes
___ Colic/Reflux

Are there any other symptoms I should know about? _____
_____
_____

Does your child have any diagnoses? If yes, which? _____
_____
_____

The child's current condition:

Is your child accident prone?	Yes/No
Has the child had any falls down steps or from a height higher than 2 feet?	Yes/No
Has your child ever been involved in a motor vehicle accident?	Yes/No
Has your child ever been hospitalised or had surgery?	Yes/No
Has your child ever had any broken bones or sprain injuries?	Yes/No
Is your child on medication?	Yes/No
Has your child had spinal curvature (scoliosis) examination by a doctor?	Yes/No

Does your child have a learning disorder?	Yes/No
Does your child have poor posture?	Yes/No
Is your child nervous, or has anyone suggested that your child was nervous?	Yes/No
Does your child show signs of twitching or excessive talking to themselves?	Yes/No
Does your child have any behavioural issues?	Yes/No

Any other information or details I should know about your child? _____
_____
_____
_____

If you could improve one aspect of your child's health or behaviour, what would it be? _____
_____
_____

On a scale of 1-10, how much stress in child's life currently? 1 2 3 4 5 6 7 8 9 10

Consent Form

By signing this form, I agree and consent to the healing work for my child.

I understand that with any healing process and work on my child's body, their symptoms may worsen before they get better.

I understand that Spinal Flow is a gentle modality and there are no contraindications for the treatment.

I understand this care is designed to assist the body with healing by helping to remove stressors from the body. I understand that healing takes time, there is no quick fix to my child's problem, and health is a process.

I have freely decided to allow my child to undergo the recommended treatment and hereby give my full consent to my child's treatment.

Client Name: _____

Signature of Parent/Guardian: _____

Date: _____