CONFIDENTIAL PATIENT RECORDS - PAEDIATRIC QUESTIONNAIRE			
Date	Childs Full Name		
Age	Date of Birth	Sex F/M	
Parent/Guardian Full Name		Age	Date of Birth
Address			
Email Address		Telephone	
Private Health Insurance		Policy and Auth no	
Name of GP and Surgery			
How did you hear about the Surrey Chiro?			

IF POSSIBLE PLEASE GIVE SOME BACKGROUND INFORMATION **TO THE BEST OF YOUR KNOWLEDGE.**

Presenting main symptom……..

Is your child on any medication?……

Has your child had chiropractic treatment before?…….where…….

Have you had chiropractic treatment before?……..where…….

Have you consulted your GP about this or any other medical condition recently?……..

For infants under 1:

birth weight…….height……..head circumference……..

Has your child had any of these illnesses (if so Age/No episodes approx):

Asthma…….

Tonsillitis……..

Otitis Media/Glue ear/Ear infections……

Colic……..

Reflux……

Headache…….

Migraines……

Hip Problems……

Do you or any one in your family have?

ARTHRITIS……

DIABETES TYPE I OR II……..

COELIAC DISEASE……..

BOWEL DISORDERS (IBS, CROHNS, ULCERATIVE COLITIS)……..

SKIN DISORDERS (ECZEMA, PSORAISIS ETC)……

ASTHMA……..

HYPERMOBILITY……..

PRIVACY POLICY CONSENT FORM

Please tick the appropriate box if you agree:

[ ] I have read on the website The Surrey Chiropractor's privacy policy and give consent to the management of my personal data.

[ ] I consent for The Surrey Chiropractor to use my contact information to send appointment reminders by SMS.

[ ] I consent to receiving telephone, SMS and email communications from The Surrey Chiropractor.