Child Questionnaire

It is our pleasure to welcome you to Brainstorm Rehabilitation. Please complete the following questionnaire. Your answers will help us to determine whether we can help you. The Comprehensive examination is part one of your thorough interview procedure. Included with this consultation will be a "conference report" appointment the following week. Please note this information is strictly confidential and will help the practice provide better care for you. Thank you.

PART A

Name: Mstr/Miss _____
First *MI* *Surname*

Gender: ☐ Boy ☐ Girl Date of birth: ___/___/___

Address: _____
Street # *Street Name* *Suburb* *PCode*

Postal Address: _____
☐ *As Above*
Street # *Street Name* *Suburb* *PCode*

Contact details:
Home PH: _____
Mobile PH: _____
Work PH: _____
E-mail: _____

Preferred method of contact number:
☐ home
☐ mobile
☐ work

Are you a member of a private health fund?
☐ No ☐ Yes - Fund Name: _____

What school does your child attend to: _____

Name(s) of other Family members (s) :	Age (s) :

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We appreciate Referrals. How did you find out about our clinic?

☐ Friend, please specify: _____
☐ Family member
☐ Yellow Pages
☐ Other (please specify): _____
☐ Another Health Professional
☐ Our Signage

PART B

People present to our clinic with various health concerns or complaints. What is your major presenting problem that we may assist your child with?

_____

_____

_____

Personal Medical History:

Please list all **operation and hospitalisations, falls and injuries** and **serious or chronic illnesses:**

Year	Problem
Year	Problem
Year	Problem
Year	Problem
Year	Problem
Year	Problem

Has your child suffered from:

Heart/Blood Vessel disease:	Yes	No	Date	Diabetes:	Yes	No	Date
High blood pressure:	Yes	No	Date	Strokes:	Yes	No	Date
Asthma/Eczema:	Yes	No	Date	Cancer:	Yes	No	Date

Are you currently seeing a GP or Specialist?

Does your child suffer from any of the following:

Unexplained fevers	Yes	No	Unexplained weight loss	Yes	No
Night Sweats	Yes	No	Does your child wake with pain?	Yes	No
Abnormal bleeding	Yes	No			

Have any of your relatives suffered from:

Diabetes	Yes	No	Cancer	Yes	No
Heart/ Blood Vessel diseases	Yes	No	Strokes	Yes	No
Epilepsy	Yes	No	Nervous System Illness	Yes	No
Muscle, bone or joint problems	Yes	No			

Do you drink? Yes No Amount ___ units/week Do you smoke? Yes No Amount____ /day

Drug/ Medication Names	***Dosage***	***Reasons for use***

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Context of Care Information
This helps us understand your child's health goals and how they fit in with their care.

1. What are his/hers health and lifestyle goals?

_____

_____

2. List their top three priorities in life. Where do health and vitality fit in?

i._____

ii._____

iii._____

3. How do you rate his/hers present level of health? *Rate 1-10. 10 being excellent.* ( )

4. How do you rate his/hers present level of vitality? *Rate 1-10. 10 being excellent.* ( )

5. How confident are you with your child's ability to persevere with the healthy diet, lifestyle and exercise programs required for your child to achieve health and wellbeing?

a. Rate 1-10. 10 being highly confidenk ( )

6. How committed are you to improving your child's health status? ( )

a. Rate 1-10. 10 being highly committed.

2. Are you willing to change your child's diet??

Yes ( ) No ( ) Maybe ( )

Explain_____

8. Are you willing to change your child's lifestyle habits?

Yes ( ) No ( ) Maybe ( )

Explain_____

9. Are you willing to increase your child's strength and stamina with a strength resistance program?

Yes ( ) No ( ) Maybe ( )

Explain_____

10. How long do you feel it would take you to achieve your child's health and lifestyle goals?

Days ( ) Weeks ( ) Months ( ) Years ( )

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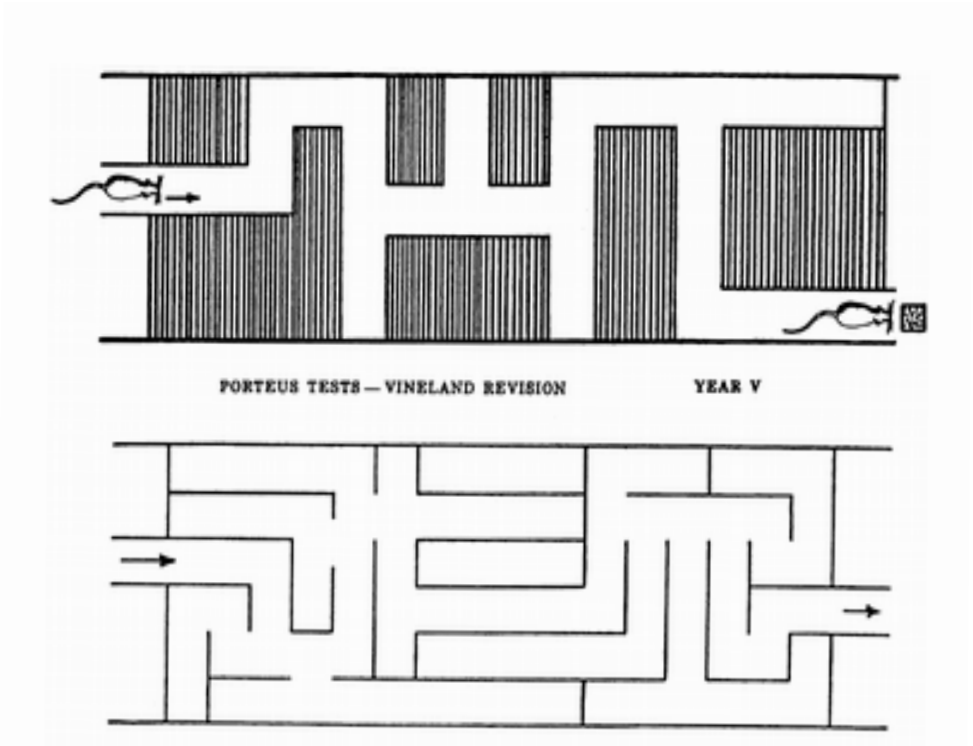
Please ask your child to complete the following activities in the space provided below and on the back of this page.

1. **Complete the maze**
2. **Draw a clock face with all the numbers and hands displaying '10 to 11' in the space below.**
3. **Draw a house**



PLEASE NOTE:
This section will be completed in the centre.

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PART E

Does your child have any problems with the following?	***Now? (Please tick)***	***In the past? (Please tick)***	***R = Right side L = Left side B = Both sides***
Tremors or uncontrollable movements of the arms, legs or body			
Stiffness, cramping, or twitching anywhere			
Weakness anywhere			
Wasting of muscles			
Dizziness, vertigo or travel sickness			
Co-ordination difficulties			
Pain in the head, jaw, eye or ear			
Ringing, fullness in the ears or altered hearing			
Unusual sensations anywhere (e.g. tingling, numbness, coldness etc.)			
Experience altered skin sensitivity			
Dryness of the mouth or eyes			
Increased tearing from one or both eyes			
Changes in sweating on either side of the body			
Coldness or puffiness in the extremities			
Dizziness or light-headedness when standing up quickly			
Fluctuations in heart rate or rhythm			
Breathing difficulties			
Altered digestion or bowel movements			
Ulcers or irritability in the stomach or bowel. Starting or stopping urine flow			
Maintaining steady urine flow			
Picky with foods			
Sleeping difficulties			
Mental arithmetic (maths)			
Decision making, planning or organisation skills			
Maintaining attention or concentration			
Behaviour, mood or personality			
Expression of thoughts or words			
Understanding speech or the written word			
Recognising people or objects			
Orientation or spatial awareness (eg map reading etc.)			
Short or long-term memory			
Anxiety or fear			
Seizures, anxiety or panic attacks			
Depression			
Confusing with left and right			

Official Use: Additional forms. ADI/ VAS/ GPCOD/ Balance Battery

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PART F

The following series of questions look at the characteristics of your child's nervous system. Rank these characteristics that match either your child's current or past behaviour. The rank scale from **0 (not evident) to 4 (very much applies).**

Characteristics	0	1	2	3	4	
Difficulty buttoning shirts	☐	☐	☐	☐	☐	L
Difficulty with tying shoe laces	☐	☐	☐	☐	☐	L
Showed some delay with crawling, standing and or walking	☐	☐	☐	☐	☐	L
Began Walking older than 2years	☐	☐	☐	☐	☐	L
Toe walker	☐	☐	☐	☐	☐	R
Prefers to eat bland foods	☐	☐	☐	☐	☐	R
Poor eye contact	☐	☐	☐	☐	☐	R
Confusion when ask to point to own different body parts	☐	☐	☐	☐	☐	R
Enjoys spinning and swings	☐	☐	☐	☐	☐	R
Often bumps into objects	☐	☐	☐	☐	☐	R
Touches or smells things compulsively	☐	☐	☐	☐	☐	R
Seems not to hear well, but hearing tests normal	☐	☐	☐	☐	☐	L
Often has dark or violent thoughts	☐	☐	☐	☐	☐	R
Motion sick issues (like car travel, swings or rides)	☐	☐	☐	☐	☐	L
Empathetic towards others	☐	☐	☐	☐	☐	L
Spontaneous emotions- cries or laughs	☐	☐	☐	☐	☐	R
Too uptight emotionally and highly strung	☐	☐	☐	☐	☐	R
Logical thinker	☐	☐	☐	☐	☐	R
Gets stuck in set behaviour	☐	☐	☐	☐	☐	R
Often displays antisocial behaviour	☐	☐	☐	☐	☐	R
Poor time management – always late	☐	☐	☐	☐	☐	R
Inability to form friendships	☐	☐	☐	☐	☐	R
Inappropriately silly	☐	☐	☐	☐	☐	R
Talks incessantly and often the same question	☐	☐	☐	☐	☐	R
Procrastinates	☐	☐	☐	☐	☐	L
Difficulty following multiple step directions	☐	☐	☐	☐	☐	L
Enjoys 'slapstick' humour	☐	☐	☐	☐	☐	R
Read at an early age	☐	☐	☐	☐	☐	R
Learns extraordinary amounts of specific facts on a topic	☐	☐	☐	☐	☐	R
Doesn't like loud noises	☐	☐	☐	☐	☐	R
Very visual; enjoys colour, patterns and images	☐	☐	☐	☐	☐	L
Daydreamer or vacant thoughts	☐	☐	☐	☐	☐	L
Has allergies	☐	☐	☐	☐	☐	R
Often gets chronic ear infections	☐	☐	☐	☐	☐	L
'Catches' the cold frequently	☐	☐	☐	☐	☐	L
Often bloated or constipation	☐	☐	☐	☐	☐	R
Sweats a lot (hands are often moist or armpits perspire a lot)	☐	☐	☐	☐	☐	R
Bed wetter	☐	☐	☐	☐	☐	L

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Patient Consent Form.

I consent to undergoing an examination to determine the cause of the condition for which I have attended the clinic. The examination may entail photographic or video recordings for inclusion in my records. Further consent will be obtained for any treatment after the examination and an explanation of the findings.

Signed: _____ Dated:_____
(Parent or Guardian to sign)

I accept financial responsibility for my consultations and treatment. Fees are due at the time of visit unless agreed in advance. Unauthorised late payments will attract fees and interest, details of which are available on request. Insurance policies are an agreement between the insurer and myself, and I am responsible for any fees I am unable to claim through a policy. I remain responsible for any fees that the Clinic is unable to recover through these schemes.

Twelve hours notice of cancellation of appointments is required or the full fee for the appointment will be due. The Clinic may waive any of the above on occasions. If the Clinic does so it reserves the right to enforce the agreement at a later date.

In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between providers within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

I understand that the practice supports the expansion of clinical knowledge and expertise. One of the ways it does this is by using clinical information for education, and scientific and case studies. All identifying information is removed from any data before it is used. I consent for my information to be used in this manner. I understand I may remove this consent at any stage without compromising my care in any way.

Signed: _____ Dated:_____
(Parent or Guardian to sign)

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