

## Candlewell Clinic

<b>Personal Details</b>	
<b>Patient Name:</b>	
<b>Parent / Guardian Name:</b>	
<b>Address:</b>	
	<b>Post code:</b>
<b>E-mail:</b>	
<b>Contact Numbers:</b>	
<b>Home:</b>	<b>Mobile:</b>
<b>Work:</b>	<b>Other:</b>
<b>Please give child's details and sign on their behalf.</b>	
<b>D.O.B:</b>	

## New Patient Questionnaire; Babies & Children

<b>GP Name:</b>
<b>Surgery Address:</b>
<b>Contact Number:</b>

See the website "Terms & Conditions" for how we control your personal information or ask to see a copy in our clinic.

<p><b>Symptom Areas:</b> Please note up to four areas of concern below then put the line designation letter in the boxes in order of priority.</p> <p>A. ....</p> <p>B. ....</p> <p>C. ....</p> <p>D. ....</p>
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**Severity of main symptoms: please tick**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>	- <input type="checkbox"/>

Best imaginable

Moderate

Worst imaginable

How long have these issues been a problem? .....

**Medical History:**

Please list any medications they are taking, either prescribed or over the counter including any homoeopathic or herbal remedies you are using:-

.....  
 .....  
 .....

In the last 12 months, has there been visits to the GP / Hospital doctor / nurse for anything other than minor / routine medical matters? Yes      No

In the last 12 months, have they seen a physiotherapist / osteopath / chiropractor (Please circle which) or other health professional? If so how many times? Yes      No      Number

In the last 12 month, have you had any of the following treatments:

X-ray or MRI or CT scan?	Yes	No
Been admitted to hospital?	Yes	No
Other medical procedure related to your condition:	Yes	No

Please note below anything found in these tests.

.....  
 .....

Any problems or changes with their bowel or bladder, e.g. stomach pain / digestive problems / bed wetting? Yes      No

Any eating problems? Yes      No

Any sleeping problems? Yes      No

Do they have headaches? Yes      No

Any changes with their eyesight, e.g. loss or double vision? Yes      No

Any changes with their sense of smell, taste or hearing?	Yes	No
Have they ever been diagnosed with any neurological problems?	Yes	No
Do they have any allergies?	Yes	No
Has your child had any serious illness or been diagnosed with a medical condition, e.g. asthma / diabetes?	Yes	No
Do they have any surgical history?	Yes	No
Please note:-.....		
Any problems with their immune system (that you are aware of) e.g. ears, nose, throat problems?	Yes	No
Have they had any trauma's (accidents / incidents) e.g. broken bones?	Yes	No
Do they suffer from growing pains / joint pain / aches etc.?	Yes	No
Do you have any disease or ill health that passes through your family?	Yes	No
Please note: ..... ..... .....		
Any difficulties in pregnancy?	Yes	No
Please note: ..... ..... ..... .....		
Any problems / complications at birth?	Yes	No
Please note: ..... ..... ..... .....		

Are there any delayed milestones?	Yes	No
Please note: .....		
.....		
.....		

Are there any behavioural or social problems?	Yes	No
Please note: .....		
.....		

Are there any schooling difficulties in reading, writing or co-ordination?	Yes	No
Please note.....		
.....		
.....		

Is there anything else that you are worried about in your child's development?		
Please note: .....		
.....		

Are there any emotional / stress issues that you feel is relevant but is easier to write down here rather than discuss in front of them?		
Please note:-.....		
.....		
.....		
.....		

Any problems with parents / guardians health?	Yes	No
Please note: .....		
.....		
.....		

Any further comments that are easier to write down rather than to discuss in front of them?	Yes	No
Please note .....		
.....		
.....		

How long have they been off school with this current episode?

Less than 1 week

1 week

2-5 weeks

6-12  
weeks

13 weeks or  
more

1 year or more

Not off  
school

**Please complete the following after completing the questionnaire.**

I confirm that I have read and understand the Patient Information document alongside and consent to the child being treated in the manner described.

I give my full consent to examination and treatment of the child.

I confirm that I am responsible for the payment of fees (including fees incurred due to missed appointments or late cancellations).

Please give your relationship to the child: .....

Parent/Guardian Print Name: .....

Parent/Guardian Signed: .....

Date: .....

# GDPR PARENTAL EXPLICIT CONSENT DATA PROTECTION AGREEMENT

## Explicit Consent

I explicitly consent to you creating and storing medical records concerning the treatment of:

....., I understand that this may include details concerning medication, treatment and other issues affecting health conditions, in accordance with the General Data Protection Regulation (GDPR).

I understand that these records will be retained until the child reaches 25, or when the treatment is ceased in order to comply with the Institute of Osteopathy legal guidelines. I understand that these records will be processed in accordance with your 2018 Privacy Notice, a copy of which I have seen.

I have read and understood the above information and have the authority to give explicit consent on behalf of the patient:

Signed ..... Date: .....

Patient name: .....

I am acting in the capacity of parent or legal guardian (please state) .....

For future appointments and administration, our preferred communication route/s is:

- Telephone
- Email
- Post
- Other (please state) .....

## Promotional Information

For the purposes of promoting healthcare including offers and advice, the Practice would also like to stay in touch with you with information that may be of interest to you and your child.

For providing promotional information you can stay in touch with me using the following methods:

- Telephone
- Email
- Post
- Other (please state) .....

Signed: ..... Date: .....