diamond valley
brain centre
diagnosing and treating neurological disorders by activating neuroplasticity
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New Patient Questionnaire (Paediatric).

Please answer as may questions as you can. This information is strictly confidential and will help the practice provide better care for your child.

General Information:

Title:..... Surname:.....First name:.....

Date of birth:..... Age:..... Sex: M/F Occupation:.....

Address:.....

..... Post code:.....

Mother's name:……Father's name:……

Phone: Home:..... Work:..... Mobile:.....

Sibling's names & ages:……

Parent's E-mail:……

GP's name & address:……
On occasions we may contact your GP to inform them of your child's care at our clinic, if you do **NOT** want us to contact them please tick this box. ☐

How did you find out about us?.....

Do you have health insurance? Yes/No If so which company?.....

Personal Medical History:

Please list **all** operations, disabilities 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 they currently seeing a GP or Specialist?.....

Do they drink? Yes/No Amount:.....units/week Do they smoke? Yes/No Amount:...../day

Do you suffer from any of the following:

Unexplained fevers …… Yes/NoUnexplained weight loss ……Yes/No

Night Sweats …… Yes/NoDoes the pain cause you to wake at night? Yes/No

Abnormal bleeding …… Yes/No

Have any of your blood relatives suffered from:

Diabetes:.....Cancer:.....

Heart problems:..... Strokes:.....

Epilepsy:..... Nervous System Illness:.....

Muscle, bone or joint problems:.....

Context of Care Information

This helps us understand your health goals and how they fit in with your care.

1. What are your health and lifestyle goals?

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

3. How do you rate your present level of health? Rate 1-10. 10 being excellent. ( )

4. How do you rate your present level of vitality? Rate 1-10. 10 being excellent. ( )

5. How do you rate your present level of lifestyle? Rate 1-10. 10 being excellent. ( )

6. How confident are you in your ability to persevere with the healthy diet, lifestyle and exercise programs required for you to achieve health and wellbeing?
Rate 1-10. 10 being highly confident. ( )

7. How committed are you to improving your health status?
Rate 1-10. 10 being highly committed. ( )

8. Are you willing to change your diet?
Yes ( ) No ( ) Maybe ( ) Explain_____

9. Are you willing to change your lifestyle habits?
Yes ( ) No ( ) Maybe ( ) Explain_____

10. Are you willing to increase your aerobic fitness with an exercise program?
Yes ( ) No ( ) Maybe ( ) Explain_____

11. Are you willing to increase your strength and stamina with a strength resistance program?
Yes ( ) No ( ) Maybe ( ) Explain_____

12. How long do you feel it would take you to achieve your health and lifestyle goals?
Days ( ) Weeks ( ) Months ( ) Years ( )

13. What do you think could stop you from achieving your health goals?
Time ( ) Commitment ( ) Resources ( ) Support ( ) Money ( )
Interest ( ) Health ( ) Other:

14. Why did you come to this clinic?

Do you 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			
Pain anywhere else			
Changes to skin sensitivity anywhere			
Unusual sensations anywhere (e.g. tingling, numbness, coldness etc.)			
Ringing or fullness in the ears			
Dryness of the mouth or eyes			
Increased tearing from one or both eyes			
Changes in sweating on either side of the body (e.g. left and right armpit)			
Coldness or puffiness in the extremities			
Dizziness or light-headedness when standing up quickly			
Fluctuations in heart rate or rhythm			
Breathing difficulties			
Digestion or bowel movements			
Ulcers or irritability in the stomach or bowel (digestive tract)			
Starting or stopping urine flow			
Maintaining steady urine flow			
Sexual dysfunction			
Sleeping			
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 your left and right			

If possible, please draw a clock face with all the numbers and hands.

Patient Consent Form.

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

Signed:..... Dated:.....

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. Whilst the Clinic is normally willing to bill 3rd party payers (eg. TAC/WorkCover) directly, I remain responsible for any fees that the Clinic is unable to recover through these schemes. I understand that full details of the claim must be provided to the Clinic (including any relevant claim numbers and authorisations) before any 3rd party payment can be accepted.
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.

I understand that my and my child's personal information will be stored both in electronic and paper form for the purposes of providing care, maintaining accounts, mailings and e-mailings from the Clinic and, where appropriate, dealing with 3rd party payers.

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 child's information to be used in this manner. I understand I may remove this consent at any stage without compromising their care in any way.

Signed:..... Dated:.....