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**Kid’s Review Questionnaire**

 ***In preparation for your next appointment, please complete online and email back prior to your session. (Parents complete for kids < 18.)***

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| Name :  | Date :  | Appointment # :  |
| What is the focus for your next appointment? |  |
| What has changed / happened since your last appointment? What are you noticing (be specific)? |  |
| What percentage have you been on your dietary regime? (0=not - 100% strictly on it) |  |
| What percentage have you been on your supplement regime? (0=not - 100% strictly on it) |  |
| Have you or are you seeing any other practitioners since your last visit? (If so, who & what for?) |  |
| Have you stopped or started any supplements or medications? |  |
| What supplements are they currently taking and how often (list brands)? |  |
| Are there any foods or substances you want to test? |  |
| What is your end goal?  |  |
| What might obstruct or prevent this? |  |
| What percentage improvement have you noticed overall? (0=none - 100% vast improvement) |  |
| What has been successful in your treatment so far, what are the positives? |  |
| What has not been successful yet, what are the negatives? |  |
| **Please Rate -** 1 = low / 10 = high (or mild-mod-severe / low-mod-high) | **0-10** | **Comments** |
| Energy levels  |  |  |
| Stress |  |  |
| Anxiety |  |  |
| Sense of Melancholy / low mood |  |  |
| Frustration  |  |  |
| Irritability |  |  |
| Restlessness |  |  |
| Twitching / twitchiness |  |  |
| Apparent tiredness / lethargy |  |  |
| Depression |  |  |
| Appetite (0=low 10=voracious) |  |  |
| Sugar cravings |  |  |
| Bread cravings |  |  |
| Headache/s |  |  |
| **IMMUNITY** |  |  |
| Any colds this month? How many/what? |  |  |
| Symptoms of any colds…? |  |  |
| Snotty / runny nose |  |  |
| Blocked nose |  |  |
| Any coughing? |  |  |
| Post nasal drip (mucus running down the back of the throat) |  |  |
| Hayfever / sneezing / watery eyes |  |  |
| Skin – quality – dry / oily / scaly / pimples |  |  |
| Nails – white spots, dry, glossy, ridged, peeling, sores beside nail, infections? |  |  |
| Any rashes, pimples, itchiness etc? |  |  |
| Mouth ulcers? |  |  |
| Sores in the corner of the mouth? |  |  |
| Infected wounds / anything not healing? |  |  |
| Injuries? |  |  |
| Growing pains? |  |  |
| **SLEEP** |  |  |
| Sleep quality |  |  |
| What time are they going to bed? |  |  |
| How long does it take to go to sleep? |  |  |
| Any snoring or suffocating sounds? |  |  |
| Number of times they wake? What time/s? How long to go back to sleep -  |  |  |
| Are they sleeping with phones / screens in the room?  |  |  |
| Any night sweats or sweating? |  |  |
| Restlessness at night?  |  |  |
| Restless legs or feet? |  |  |
| Sleepiness in the evenings |  |  |
| Energy in the evenings |  |  |
| Dreams / Nightmares? |  | What kind of dreams do they tend to have (eg: about people, running, flying, knives, war, monsters, destruction, beautiful things…?) |
| Up to wee at night? What time/s? |  |  |
| Bedwetting? |  |  |
| Sluggishness in the mornings |  |  |
| Average hours of sleep a night |  | What time to bed:What time up: |
| **GUT** |  |  |
| Any nausea / tummy aches? |  |  |
| Episodes of vomiting? |  |  |
| Abdominal bloating |  |  |
| Belching / burping |  |  |
| Farting (how often, is it odourous?) |  |  |
| How are their stools? (well formed & easy to pass / loose / diarrhoea / mucus / slime / blood / constipation / frequency? |  |  |
| How often do they have a bowel motion...?A number of times a day / daily / every other day / weekly … How long does it take? |  |  |
| **MOOD** |
| **Describe your child’s mood of late:** |
| Happy / contentment |  |  |
| Sense of Wellbeing |  |  |
| Angry |  |  |
| Irritable |  |  |
| Frustration / Irritability |  |  |
| Fits of rage / aggression |  |  |
| Teariness / Emotionality |  |  |
| Cuddliness |  |  |
| Clingy |  |  |
| Sad |  |  |
| **SCHOOL** |  |  |
| **How has school been this month?** |
| How is their Mental Clarity / memory |  |  |
| Any learning/focus issues? |  |  |
| Any school stress or dramas? |  |  |
| Modem in classroom? (where) |  |  |
| Modem/WIFI on at night? |  |  |
| **TECH USE**  |
| How much phone app time have they had per day/week |  |  |
| What time/s do they stop using their phone / device? |  |  |
|  |  |  |
| What games / apps are they using? |  |  |
| How much television / shows have they been watching a day/week?  |  | What are they watching lately? |
| How much time gaming have they been spending a day/week? |  |  |
| **EXERCISE / OUTSIDE TIME***:*  |
| What exercise are they doing & how much?Rate the intensity MILD/MODERATE/HIGH |  |
| **BODY:**  |
| Muscle tension / hardness / knots – WHERE? |  |  |
| Any body pain? |  |  |
| Neck  |  |  |
| Upper Shoulders |  |  |
| Arms & elbow/s |  |  |
| Hands |  |  |
| Middle Back |  |  |
| Lower Back |  |  |
| Joints |  |  |
| Legs & Knees |  |  |
| Feet |  |  |
|  |
| **Medical Update** |

|  |  |
| --- | --- |
| Are there any medications they have started or stopped, or any medical appointments you have attended since your last visit?  |  |
| Have they seen any other health care professionals, started or stopped any supplements, herbs or other Natural remedies?  |  |
| How many Neurofen, Panodol, Antibiotics or other over the counter medicines have they used since their last appointment?  |  |

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| **VACCINES:** Have you have had any vaccines lately? If yes, what and what were the dates?**PCR TEST:**Have you done any RAT or PCR tests for Covid? What date/s?Results?  |
| Is there anything else? |