☆IN CONFIDENCE☆

Child Pre Session Questionnaire

Please fill out the following questions as much as you can prior to your child's session. By being honest ensures the most optimus results, therefore please disclose anything that could potentially cause any harm so that precautions can be taken to minimise this. Ideally if you could please email it back to mandy@optimustruebeing.com.au, or if your computer is not playing nicely, then you can bring it along with you to your child's first session. Many Thanks ☺

Name: **Person filling out this form/Relationship:** **Date:**

What are the main reasons for this consultation? Problems/pains/issues? (Rate pain 1=no pain, 10=max pain)

How was your child's birth?

Please list your child's Hobbies/Interests:

What's their Sleeping Pattern like? How many hours sleep do they get?
(Light/Average/Heavy sleeper)
(Awake Refreshed/Tired)
(Up to the toilet @ night, bed wetter etc)

What sort of Exercise do they do? (Type/Frequency)

What is your child's diet like? (Water intake, Veg, Fruit, Smoking, Drink Alcohol)

Do they take any Supplements/Herbs/Medications? Vitamins/Minerals, etc

Do they have any Food Cravings/Preferences? (Sweets/Chocolates/bitter/spicy, hot/cold, etc)

Do they have any allergies?

Do they have any Amalgam Fillings (silver)?

How is your child's energy on a scale 1=no energy, 10=full of energy? When do they have most/least energy

Do they get Stressed?: On an average & at extremes please rate 1=no stress, 10=max stress…
What makes them stressed? How do they feel?

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What is their Medical History? e.g. Allergic Reactions, Anxiety/Depression/Nervous/panic attacks, Arthritis (Juvenile), Asthma, Birth difficulties, Bladder weakness, Blood Pressure, Bone/structural weakness/deviations, Breathing probs, Cancer, Ear probs/infections, Emotional, Eye strain/pain/blotches/glasses, Headaches/Migraines, Hearing difficulties, Heart Conditions, Liver probs/Hepititis, Muscle pain/aches, Neurological problems, Nose discomfort/dripping/sneezing, Psychiatric History, Side Effects (other treatments), Syncope/fainting/epilepsy, etc

Are there any Medical difficulties within your Family? As above for Mum/Dad/Grandparents/Brothers/Sisters

If Menstrual Cycle present how is it?
Duration?
Light/Heavy?
Emotions – Cranky, weepy, etc?

What is their Digestion like? Do they open their bowels regularly & what is regular for them? Any difficulty? bloating/pain? constipation/diarrhoea?

Do they have any Fears? (Heights/small spaces/animals/insects/performance, etc)

Do they Dream? any vivid/repeating/nice/concerning

How would you describe your child? (Happy, Sad, Lonely, playful, fast/slow learner, etc)

Have they been Vaccinated? & Any recent/new ones?

Do they use orthotic appliances in their shoes?

Do they experience back pain, neck pain or other physical pain?

Do they experience ringing in the ears, clicking/popping of the jaw or facial pain?

If you are unsure about anything, you can contact Mandy on…
mandy@optimustruebeing.com.au 0406 856 966
or write it down on this sheet to talk about during your child's session.
☺ Thank you! Be the Star You Are ☆, Mandy ☺