MATRIX HEALTH SOLUTIONS
Expanding the Horizons of Well-being

CHILDREN'S CONFIDENTIAL HEALTH QUESTIONNAIRE

Dear Parents/Guardians:
Welcome. It is our hope that we can assist you with your current and future health concerns. Our focus is health improvement, maintenance, prevention and education. Any current health problems may be indicators of underlying imbalances. Part of our job will be to explore your overall health status and to advise you on measures to ensure optimal well-being. During the course of you examination and treatments, please feel free to comment, ask questions, and provide us with feedback. We feel that the more you know about yourself, the more active a role you can play in restoring and maintaining your own health. Together, we can form a team on the side of a healthy future.

Please complete this questionnaire with care, on behalf of your child. Your answers will help us to determine the most effective health care for your child. Please print.
Thank you.

NAME:__ _____ DATE:_____
Mother's Name: _____ Father's Name: _____
Phone: H ( ) _____ Alternate Phone: ( ) _____
Address: _____
street city postal code
Date of birth (DD/MM/YY):_____ Age:_____
Weight:_____ Height :_____

What is your chief concern about your child's health? _____
_____
What else would you like to see changed in their health? _____
_____
_____
If there is a specific condition, how long has it been occurring?_____
List any practitioners seen for this reason._____
_____
List diagnoses, types of treatment, medications, etc. _____
_____

Is there a relative with similar problems? ☐ Yes ☐ No
If yes, please provide details: _____
_____

List any medications your child is presently taking, and doses. _____
_____

Has your child had any x-rays taken in the last three years? ☐ Yes ☐ No
Please list areas: _____
_____

Has your child lost any days at school recently? ☐ Yes ☐ No Dates: _____
_____

What do you feel is causing your child's health problems? _____

_____

When .was your child last well? _____

Does your child have regular sleep habits? ☐ Yes ☐ No How many hours?_____

Early riser? ☐ Yes ☐ No Difficulty falling asleep? ☐ Yes ☐ No

Nightmares/Night terrors? ☐ Yes ☐ No

Please list any vaccinations your child has had, include age and any adverse reactions they experienced?

Vaccination	Age	Adverse Reactions

Please indicate which of the following childhood diseases your child has had?
Please indicate if it was mild, average or severe.

	Yes (Y) or No (N)	Age	Severity: Mild (M), Average (A) or Severe (S)
Roseola			
Rubella/German Measles			
Rubeola/Measles			
Chicken Pox			
Mumps			
Scarlet Fever			
Pertussis/Whopping cough			
Strep Throat			
Impetigo			
Mononucleosis			

Please indicate the occurrence of the following, along with details and dates:

SURGERY:_____ HOSPITALIZATION: _____

_____ _____

_____ _____

ACCIDENTS:_____ MAJOR ILLNESSES:_____

_____ _____

_____ _____

LOSS OF CONSCIOUSNESS:_____ SEIZURES: _____

_____ _____

_____ _____

Is there a history of any of the following in your family? (Please circle and state relationship of family member):

Alcoholism	Cancer	Heart Disease	Schizophrenia
Allergies	Cataracts	Hyperactivity	Stomach ulcers
Arteriosclerosis	Celiac	Kidney Disease	Stroke
Arthritis	Colitis	Learning Disability	Tuberculosis
Asthma	Depression	Mental Disease	Yeast Infections
Bed Wetting	Diabetes	Muscular Dystrophy	Venereal Disease
Candida Albicans	Epilepsy	Multiple Sclerosis	

What was the level of health of both parents prior to conception?

Father: ☐ poor ☐ fair ☐ good ☐ excellent

Mother: ☐ poor ☐ fair ☐ good ☐ excellent

What was the level of health of the mother during the pregnancy?

☐ poor ☐ fair ☐ good ☐ excellent

Comments: _____

What supplements/vitamins was the mother taking during the pregnancy? _____

_____

What medications did the mother take during the pregnancy?

Prescription :_____

Over the counter: _____

Did the mother smoke before the pregnancy? ☐ Yes ☐ No

If yes, how many cigarettes per day?_____

Did the mother smoke during the pregnancy? ☐ Yes ☐ No

If yes, how many cigarettes per day?_____

Does anyone in the household currently smoke? ☐ Yes ☐ No

Did the mother drink alcohol during the pregnancy? ☐ Yes ☐ No

If yes, indicate beverage, amount and frequency:_____

The mother's diet during the pregnancy was: ☐ poor ☐ fair ☐ good ☐ excellent

What was the mother's emotional state during pregnancy?

☐ excellent ☐ stable ☐ stressed ☐ very stressed

What is the emotional climate of the child's home presently?

☐ excellent ☐ stable ☐ stressed ☐ very stressed

How was the birth of the child? Indicate if there was a Caesarian section, forceps, or any complications: _____
_____
_____

Has your child had colic? ☐ Yes ☐ No
Was your child breast-fed? ☐ Yes ☐ No If yes, for how long?_____
If no, what formula were they given? _____
What solid foods were started prior to 6 months of age?

Food	Age

What additional foods were introduced between 6 to 9 months of age?

Food	Age

List child's favorite foods_____
_____
Please list what is a typical:
Breakfast _____
Lunch_____
Supper_____
Your child's appetite is: ☐ poor ☐ fair ☐ good ☐ excellent
What supplements/vitamins does your child take on a regular basis? _____
_____
What are your observations about your child's temperament? _____
_____
Is your child's physical development:

☐slower than average ☐ average ☐faster than average

Is your child's mental/emotional development:

☐slower than average ☐ average ☐faster than average

How is your child's behavior and performance at school? _____
_____
What form of heating do you have presently?

☐oil ☐electric ☐gas

Are there any pets in the household? ☐ Yes ☐ No -If yes, what kind? _____
_____

Informed Consent Statement

I hereby request and consent to the performance of assessment and treatment procedures at the Matrix Institute, or when necessary, provided by authorized clinic staff. These may include diagnostic procedures, laboratory tests and various forms of treatment, including manual therapy, physical therapy, lifestyle and nutritional counseling, remedial exercise, and other procedures or services as may be deemed necessary, as part of my health care program.

I understand that all information about my health care and health history is confidential, and is required by clinic staff, so that the most effective and beneficial care may be provided. Any communication between my practitioners and myself will remain confidential, unless I provide written consent to release it to specifically designated parties, or unless Clinic staff are legally required to disclose such information.

I understand that any treatment or advice provided to me at the clinic, is not being provided in the place of, or to the exclusion of, any other treatment or advice that I may now be receiving or, may in the future receive, from a physician, surgeon or any other licensed health care provider.

I further understand and am informed that, as in all health care, there are some very slight risks to treatment. In particular, Matrix Therapy, which may include the treatment of musculoskeletal structures and internal organs, is a very gentle form of treatment, which does not have any inherent risks. It is possible, however, to experience an increase of symptoms initially, or fatigue following treatment, or even feel new sensations particularly after the first treatment. These tend to be short-lived (1-3 days) and are considered very normal responses. I also understand that I am encouraged to ask such questions as I may have at any time and to advise Clinic staff of any unusual symptoms, which may or may not be associated with any of the above procedures or advice provided.

I acknowledge that I am accepting or rejecting this care of my own free will, and that I am free to refuse any treatment or withdraw as a patient at any time. I understand that the ultimate responsibility for my health care is my own and that the clinic staff is here to support me in these efforts. I understand that the Matrix Institute and the clinic staff reserve the right to discontinue their services where it is apparent that my expectations and the type of services provided are not compatible.

I am aware of the fee schedule and understand that fees for services are payable at the time of the appointment and that certain procedures may not be covered by insurance. I hereby agree to pay my account at the conclusion of each and every visit. I further acknowledge and agree that I will be charged the full fee for any missed appointments, unless I have advised the Matrix Institute of my cancellation no less than 48 hours in advance of the scheduled appointment.

TO BE COMPLETED BY PATIENT OR LEGALLY AUTHORIZED GUARDIAN:

_____	_____
PRINT PATIENT'S NAME	SIGNATURE OF PATIENT (OR LEGAL GUARDIAN)

Dated this _____ day of _____, _____.
Day Month Year