

**Parents Full Names:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Other**:Step Parent/Carer/Grandparent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Post/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_Country:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Days and Times:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All children**

1. First Childs Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_

2. Second Childs Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

3. Third Childs Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_

4. Fourth Child Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_

**Medical History:** Please identify if any of the following applies (Tick & identify child number)

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ | Autism:\_\_\_\_\_\_\_\_\_ | ☐ | Nightmares/Night Terrors:\_\_\_\_\_\_ |
| ☐ | ADD/ADHD:\_\_\_\_\_\_\_\_ | ☐ | ObsessiveBehaviour:\_\_\_\_\_\_\_\_ |
| ☐ | Anger:\_\_\_\_\_\_\_\_ | ☐ | Sibling Rivalry:\_\_\_\_\_\_\_ |
| ☐ | Asperges Syndrome:\_\_\_\_\_\_\_\_\_\_ | ☐ | Skin Issues:\_\_\_\_\_\_\_\_\_\_ |
| ☐ | Anxiety:\_\_\_\_\_\_\_\_ | ☐ | Sleep Issues:\_\_\_\_\_\_\_\_\_\_ |
| ☐ | Bedwetting:\_\_\_\_\_\_\_\_\_ | ☐ | Tiredness:\_\_\_\_\_\_\_\_\_ |
| ☐ | Epilepsy :\_\_\_\_\_\_\_\_\_\_ | ☐ | Thumb Sucking:\_\_\_\_\_\_\_\_\_\_ |
| ☐ | Fear /Phobias:\_\_\_\_\_\_\_\_ | ☐ | Asthma:\_\_\_\_\_\_\_\_ |
| ☐ | Confidence Issues:\_\_\_\_\_\_\_\_\_ | ☐ | Agression:\_\_\_\_\_\_\_\_ |
| ☐ | Depression:\_\_\_\_\_\_\_\_\_\_ | ☐ | Food /Eating Issues:\_\_\_\_\_\_\_\_\_\_ |
| ☐ | Food/Eating Issues:\_\_\_\_\_\_\_\_\_\_ | ☐ | Gender Dysporia:\_\_\_\_\_\_\_\_\_ |
| ☐ | Headaches:\_\_\_\_\_\_\_\_\_\_\_ | ☐ | Poor Social Skills:\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ | Stress:\_\_\_\_\_\_\_\_\_\_ | ☐ | Separation Anxiety:\_\_\_\_\_\_\_\_\_ |
| ☐ | Weight Gain/Loss:\_\_\_\_\_\_\_\_\_\_ | ☐ | Toiletry Issues:\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ | Other:\_\_\_\_\_\_\_\_ | ☐ | ODD:\_\_\_\_\_\_\_\_ |

**Main Concern**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list Current Medications or Therapies (include nutrients): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

V2/2022