

**Parents Full Names:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Other/ Stepparent/ Carer/Grandparent:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Country:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Days and Times:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All children:**

First Childs Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_

Second Childs Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_

Third Childs Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_

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 of Child needing assistance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list Current Medications or Therapies (include nutrients):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_