

Childs Surname	Forename(s)	Date of Birth dd/mm/yy	Child
Address: .....		Postcode: .....	
Telephone, Home: .....		Mobile: ..... Work: .....	
GP/Health Centre Address: .....		Phone: .....	
E-mail address .....			
<b><i>Please circle Y or N and insert a date, as appropriate, in the boxes below</i></b>			
Has he/she had meningitis/Encephalitis? <b>Y/N</b> Date: .....		Has he/she had a heart condition? <b>Y/N</b> Date: .....	
Has he/she had a cerebral bleed? <b>Y/N</b> Date: .....		Has he/she had a blood clot (embolism/thrombosis)? <b>Y/N</b> Date: .....	
What medications is he/she taking, if any?			
What other treatments has he/she most recently had, or still having? e.g. Physiotherapy, Osteopathy			
<b><i>If he, or she, suffers from any of the following, then tick the appropriate box, and add any details that you feel may be helpful. Leave the others blank.</i></b>			
<input type="checkbox"/> Jaw Pain or "TMJ syndrome"	<input type="checkbox"/> Recent teeth extractions, or past orthodontic treatment		
<input type="checkbox"/> Poor Sleep	<input type="checkbox"/> High or Low Blood Pressure		
<input type="checkbox"/> Vertigo or Travel Sickness	<input type="checkbox"/> Operations for Sight problems, e.g. for squint		
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Chest Pains or Palpitations	<input type="checkbox"/> Headaches or Migraines		
<input type="checkbox"/> Dyslexia, Dyspraxia or Dysphasia	<input type="checkbox"/> Hearing Problems or Tinnitus		
<input type="checkbox"/> Thrush	<input type="checkbox"/> Digestive Problems		
<input type="checkbox"/> Nervous Tics or Tremors	<input type="checkbox"/> Regular Colds or Infections		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression		
<input type="checkbox"/> Chronic Tiredness or Lethargy	<input type="checkbox"/> Poor Circulation		
<input type="checkbox"/> Back Pain or Sciatica	<input type="checkbox"/> Neck or Arm or Shoulder Pain		
<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Asthma		
<input type="checkbox"/> Skin Problems, e.g. eczema	<input type="checkbox"/> Allergies		

Please say if there was anything abnormal about their birth (e.g., premature/forceps etc.)

Was there anything else of note about the pregnancy ?

Please list all surgical operations and serious illnesses:

Please list any falls, or injuries, or accidents:

*Please indicate, in order of importance, the problems you would like help with:*

<b>1.</b>	<b>2.</b>
<b>3.</b>	<b>Any comments?</b>

**Therapists Notes**      **Date:**.....

**Patient Release, Cancellation, Consent to Treatment & Notes Confidentiality**

I, ..... (relationship, e.g., Mother, Father, etc. ....)

I request and consent to treatments for my child from Eric Demmon. I understand that these treatments may require the use of various hands-on approaches, including CranioSacral Therapy. I realise that the particular therapeutic outcomes of these treatments cannot be predicted with certainty and no guarantee can be made regarding any particular result or outcome.

I understand that contact details will be held by Eric Demmon in data files, but will not made available to anyone else.

I understand that I must give at least **24 hours notice to cancel an appointment**, otherwise I may incur a £10 fee.

Signature of parent/guardian ..... Date: .....