SECONDARY SCHOOL AGE CHILD MEDICAL HEALTH FORM
(13 YEARS AND ABOVE)

Please ensure you have completed a Patient Contact Details Form prior to completing this Medical History Form.

Name *your full name*

Date of Birth *dd/mm/yyy*

Please provide a brief description of your problem? *max 300 characters*

Do you know what caused your problem? *max 300 characters*

Is the problem improving? *max 300 characters*

Are your symptoms worse during the day or at night?	○ Night ○ Day

At the onset of your problem, did you experience any trauma, illness/infection or other significant event?

Does your pain wake you at night?	○ Never ○ Rarely ○ Frequently ○ Always

Describe what aggravates/relieves your problem?

Have you had any other treatment for your current problem? *optional*

Who was the practitioner? *optional*

Did you find the treatment effective?	○Yes ○ No

Please rate the severity of your symptoms: *10 being the most severe pain (circle one)*
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does your current problem involve any of the following:	Yes	No
Pain in either arm and leg	○	○
Tingling in either arm and leg	○	○
Numbness in either arm and leg	○	○
Weakness in either arm and leg	○	○
"Weird" sensations in either arm and leg	○	○

Please indicate yes/no to the following:	Yes	No
Do you think you have a healthy diet?	○	○
Do you take vitamin supplements?	○	○
Do you exercise regularly?	○	○

Please list any sports/hobbies you have:

Please comment on any signicant surgery and hospitalisation

Are you currently taking any form of medication? If Yes please list medications.

Do you have any other significant medical history? *Eg. Cancer, Diabetes, Heart Disease,/Hypertension, Asthma, Fractures, Sports Injuries, Falls*

Have you ever had a car accident? If Yes please describe? *No matter how trivial please describe details*

Please indicate yes/no to the following	Yes	No
Do you have frequent headaches?	○	○
Do you feel stressed?	○	○
Have you experienced dizziness/vertigo/faints/blackouts?	○	○
Do you suffer from fatigue?	○	○
Do you suffer from night sweats/fever?	○	○
Do your joints swell?	○	○
Have you lost/gained weight in the past year?	○	○
Do you have digestive problems?	○	○
Have you noticed any blood or mucus in your bowel movements?	○	○
Do you suffer from shortness of breath or chest pain on exertion?	○	○
Do you have any pain or increased frequency on passing urine?	○	○
Do you have any unusual lumps/swelling on your body?	○	○
Do you have any problems with hearing? (Including ringing in ears)	○	○
Do you have any problems with smell or taste?	○	○
Are you easily depressed?	○	○
Do you suffer from anxiety?	○	○
Do you have poor sleep?	○	○
Do you have any problems with your vision?	○	○
Do you have poor balance?	○	○

I consent for my information to be communicated to my GP and/or other relevant health professionals when appropriate.
○ I give consent ○ I do not give consent