Client History

Full Name:

Email:

Contact Details

Address **Postcode**		**Occupation:**	
Date of Birth		**Contact Phone**	
Allergies or intolerances	No	Yes	
Asthma	No	Yes	
Neck or Back injuries	No	Yes	
Seizure disorder	No	Yes	
other significant diagnoses (current and past)	No	Yes	Details:
Current or past therapies & therapists	No	Yes	Details:
What are the challenges that bring you here today?			
Emergency Contact Person & Contact Details			

Pregnancy/Birth Details

Birth Weight			
Born at Term	Yes	No	If No, at what week?
Caesarean	Yes	No	
Particularly **fast** delivery?	Yes	No	
Particularly **slow** delivery?	Yes	No	
Any pregnancy issues or particularly stressful periods during the pregnancy? (eg Bed rest, IVF, surrogacy, multiple ultrasounds, adoption etc)			
Issues **during** delivery? *Please describe (eg forceps, vacuum, induction etc)*			

Issues **after** delivery? *Please describe (eg feeding, jaundice, isolette, maternal complications etc)*

Infant Period – 0-18 months

Please circle yes or no as far as you are aware of the following matters.

Difficulties with sleep. A lot of screaming.	No	Yes
Strikingly sluggish or inactive	No	Yes
Crawled on hands and knees	No	Yes
Toe walked	No	Yes

Present Challenges

Low tolerance to stress	No	Yes
Difficulty making eye contact	No	Yes
Struggle to sit still	No	Yes
Fear of the dark	No	Yes
Anxious	No	Yes
Social phobias, panic attacks	No	Yes
Balance problems – difficulty going on escalators or stairs	No	Yes
Fear of heights	No	Yes
Dominant hand shown	No	Yes Left Right
Motion Sickness	No	Yes
Poor balance	No	Yes
Overflexible joints	No	Yes
Clumsy/uncoordinated	No	Yes
Slouches over table when writing	No	Yes
Easily disturbed/distracted	No	Yes
Mouth movements when writing	No	Yes
Areas of frequent pain in the body	No	Yes Where?
Falls or trips often	No	Yes
Areas of tension in body	No	Yes Where?
Poor endurance and stamina	No	Yes
Feel invisible	No	Yes

Shy, problems asserting oneself	No	Yes
Over-active	No	Yes
Oscillate between over-activity and passivity	No	Yes
Impulsive	No	Yes
Fits of emotion	No	Yes
Low self-esteem	No	Yes
Withdraw from social situations	No	Yes
Find it difficult to trust	No	Yes
Sensitivity to loud noises	No	Yes
Loose ankles, easily sprained	No	Yes
Perfectionist, fear of failure	No	Yes
Sweet –tooth, regular sugar cravings	No	Yes
Teeth grinder	No	Yes
Inability to voice needs, desires and opinions	No	Yes
Regularly bite cheek or tongue accidentally when eating	No	Yes
Not physically affectionate	No	Yes
Compulsive collector	No	Yes
Oversensitive to • Sound • Light • Touch	 No No No	 Yes Yes Yes

Questionnaire compiled from:
Dempsey, Moira. (2012). ***RMT for Focus, Organisation and Comprehension*** *– RMTi Foundation Series Level One. (Rhythmic Movement Training International)*

Current Lifestyle

Timing of meals:

Breakfast		Afternoon snack (if any)	
Morning snack (if any)		Dinner	
Lunch		Supper (if any)	

Servings per week of:

Fish		Starchy Veg		Tea		Soft Drink	
Chicken		Other Veg		Coffee		Cakes/Pastries	
Eggs		Fruit		Alcohol		Chocolate/sweets	
Red meat		Nuts and Seeds		Take-away			

Sleep:

Time you go to bed	
Time you fall asleep	
Time you wake up	
Sleep Quality /10 *(1 being the worst 10 being the best)*	
How refreshed do you feel in the morning /10 *(1 being the least 10 being the most refreshed)*	
What times do you feel tired through the day?	

Energy Levels:

Rate your energy /10 at the following times of the day with 1 being the least energetic and 10 being the most energetic.

5-7am		3-5pm	
7-9am		5-7pm	
9-11am		7-9pm	
11-1pm		9-12pm	
1-3pm			

Movement:

Types of movement you are currently doing (if any)	Time of the day you usually so this session	Number of sessions per week
Moderate to vigorous cardio		
Light cardio		
Weight or Resistance training		
Stretching/Yoga/Pilates		

Hobbies, other activities and interests:

Who do you have to support you through this program?

Consent to Collect Information & Waiver Form

Head Over Hills respects the rights of individuals and their families to privacy. In order for Head Over Hills to provide you and/or your family with a high standard of service, we require some personal information from you. To collect this information we require your consent.

When you first request services from Head Over Hills, we request that you complete:

1. this Consent to Collect and Release Information Form
2. an RMT or ph360 Client Information Form
3. where RMT services have been requested, a Rhythmic Movement Training International Consultation Session Information and Release form.

All of these forms will be provided to you prior to the commencement of our services with you. You may ask us to explain these forms to you.

You have a right to withdraw or limit consent at any time. However, if you do so, this may make it very difficult for Head Over Hills to provide the appropriate services to you or your family.

The information you provide us with, will be used for:

a. Administrative purposes
b. Billing you directly for the services provided
c. Informing and delivering services provided to you
d. Monitoring progress and changes you experience over time
e. Responding to queries or complaints
f. Selling and marketing our products and services
g. Client surveys, events or other programs
h. In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your functional health status

There may be times where Head Over Hills is required to work closely with other agencies to coordinate or inform the best support for you or your family. To do this, your informed consent for the sharing of information will be sought and respected in all situations unless:

- we are obliged by law to disclose your information regardless of consent or otherwise
- it is unreasonable or impracticable to gain consent or consent has been refused and
- the disclosure is reasonably necessary to prevent or lessen a serious threat to the life, health or safety of a person or group of people.

Head Over Hills has a Privacy Policy that is available on request. This policy is guided by key legislation including (but not limited to) the Privacy Act (1988) and provides detailed guidelines on the collection, use, disclosure and security of your information; advises how you may request access to, and correction of, your personal information; and how you may complain about a breach of your privacy and how we will deal with such a complaint.

Keeping children safe is an important role of all health care providers. If there are any concerns regarding a child's safety, welfare or wellbeing, Head Over Hills may be legally obligated to disclose information without parental consent under Section 31 of the Children and Young People (Safety) Act 2017.

If you need any further information or have any questions or concerns about the collection and use of your personal information, please discuss with Head Over Hills.

Re: _____
(Client's Name)

I, _____
(Client)

have read the above information and understand the reasons for the collection of my personal information and the ways in which the information may be used and disclosed, and I agree to that use and disclosure.

- I understand that it is my choice as to what information I provide, and that withholding or falsifying information might act against the best interests of myself or my family in receiving services from Head Over Hills.
- I am aware that I can access my personal information on request and if necessary, correct information that I believe to be inaccurate.
- I understand that if, in exceptional circumstances, access is denied for legitimate purposes, that the reasons for this and possible remedies will be made available to me.
- I have been given an opportunity to obtain a copy of Head Over Hills' Privacy Policy.

Waiver

I hereby give my consent to receive treatments and coaching and I acknowledge I am doing so at my own risk. My health and safety with respect to such services are my sole responsibility. My decision to receive services is voluntary, and I know of, understand and assume any and all the risks associated therewith. In exchange for receiving services for myself and on behalf of my heirs, executors, administrators and personal representative, hereby waive, release, discharge and hold my therapist harmless from any and all liability for an and all injuries, including damages or claims relating to or resulting from my receipt of the services, now or in the future, foreseen or unforeseen.

- If I experience pain or discomfort during the session, I will immediately inform my therapist. I will not hold my therapist responsible for any pain or discomfort I experience before, during or after the session.
- I understand the services offered today are not a substitute for medical care.
- I understand that RMT is an educational experience and that there may be follow up movements or activities to be done at home.
- I understand that I am participating in these session to bring about a better learning potential.
- I understand that my therapist is not qualified to carry out a medical examination or provide a diagnosis and I agree not to interpret their comments as medical advice.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform my therapist of any changes in my health and medical condition. I understand there shall be no liability on the therapist's part should I forget to do so.
- By signing this release I hereby waive and release my therapist from any and all liability past, present and future relating to this treatment, program or coaching.

_____ _____
Signature Date