Client History

Name:

Date of Birth:

Contact Details

Address **Postcode**		**Email**	
Caregivers' Names		**Contact Phone Numbers**	
Allergies, intolerances or sensitivities	Yes ☐	No ☐	
Asthma	Yes ☐	No ☐	
Neck or Back injuries	Yes ☐	No ☐	
Seizure disorder	Yes ☐	No ☐	
other diagnoses	Yes ☐	No ☐	Details:
Past or current other therapies & therapists	Yes ☐	No ☐	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 and describe particulars or the severity of the challenge if yes.

High Fever	No☐	Yes☐
Convulsions	No☐	Yes☐
Periods of serious or recurrent illness	No☐	Yes☐
Strong reaction to vaccination	No☐	Yes☐
Walked before 10mths	No☐	Yes☐
Walked after 15mths	No☐	Yes☐
Began to speak after 18mths	No☐	Yes☐
Difficulties with sleep. A lot of screaming.	No☐	Yes☐
Strikingly sluggish or inactive	No☐	Yes☐
Feeding Problems	No☐	Yes☐
Frequent ear infections	No☐	Yes☐
Army Crawled	No☐	Yes☐
Crawled on hands and knees	No☐	Yes☐
Bum shuffled	No☐	Yes☐
Rolled	No☐	Yes☐
Did one leg trail behind when crawling	No☐	Yes☐

Childhood 18mths – 18yrs

Please circle yes or no and describe any relevant particulars or the severity of the challenge if yes.

Defiant period at the age of 2 or 3 years?	No☐	Yes☐ Normal☐ Marked ☐ Slight☐
Bed-wetter after the age of 5	No☐	Yes☐
Is your child coping with school generally?	No☐	Yes☐
Likes tight clothes	No☐	Yes☐
Struggles to sit still	No☐	Yes☐
Fear of the dark	No☐	Yes☐
Anxious	No☐	Yes☐
Dominant hand shown	No☐	Yes☐ Left☐ Right☐

Motion Sickness	No☐	Yes☐
Hunched posture	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☐
Toewalks	No☐	Yes☐
Falls or trips often	No☐	Yes☐
Tense	No☐	Yes☐
Poor endurance and stamina	No☐	Yes☐
Unobtrusive, passive, apathetic	No☐	Yes☐
Shy, problems asserting oneself	No☐	Yes☐
Over-active	No☐	Yes☐
Oscillates between over-activity and passivity	No☐	Yes☐
Impulsive	No☐	Yes☐
Fits of emotion	No☐	Yes☐
Has good ideas but can't put them into writing	No☐	Yes☐
Turns page on angle when writing	No☐	Yes☐
"W" Sitter	No☐	Yes☐
Difficulties crossing the midline	No☐	Yes☐
Hesitates when starting movements	No☐	Yes☐
Poor Memory	No☐	Yes☐
Dribbles excessively	No☐	Yes☐
Sucks thumb, fingers or clothes	No☐	Yes☐
Chews pens, fingernails or other objects	No☐	Yes☐
Excessively high arched palate	No☐	Yes☐
Crowded upper teeth	No☐	Yes☐
Messy eater	No☐	Yes☐

Frequent mood swings	No☐	Yes☐
Difficulty accepting criticism	No☐	Yes☐
Inflexible and needs routine	No☐	Yes☐
Procrastinates	No☐	Yes☐
Craves sweet food	No☐	Yes☐
Difficulty with:		
• Learning to do up buttons	No☐	Yes☐
• Tying shoelaces	No☐	Yes☐
• Holding a pen	No☐	Yes☐
• Hopping on one leg	No☐	Yes☐
• Somersaulting	No☐	Yes☐
• Doing breaststroke	No☐	Yes☐
• Riding a bike	No☐	Yes☐
• Making friends	No☐	Yes☐
• Learning to write	No☐	Yes☐
• Throwing a ball	No☐	Yes☐
• Kicking a ball	No☐	Yes☐
• Reading	No☐	Yes☐
• Spelling	No☐	Yes☐
• Handwriting	No☐	Yes☐
• Writing an '8'	No☐	Yes☐
• Attention and concentration	No☐	Yes☐
• Foresight and planning	No☐	Yes☐
• Playing with other children/ gets into conflict	No☐	Yes☐
Sleep • settling to sleep	No☐	Yes☐
• waking during the night	No☐	Yes☐
• What time do they usually go to sleep at night		
• What time do they naturally wake		
Vision Problems • Eyes turn or cross	No☐	Yes☐

• Squints	No☐	Yes☐
• Other	No☐	Yes☐
Speech • Inarticulate speech or stutter	No☐	Yes☐
• Other	No☐	Yes☐
Oversensitive to • Sound	No☐	Yes☐
• Light	No☐	Yes☐
• Touch	No☐	Yes☐

Comment on your child's eating habits and appetite

At what approximate time of the day do they eat:

Breakfast

Morning Snack:

Lunch

Afternoon Snack:

Dinner:

Supper:

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

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/Parent/Guardian)

have read the above information and understand the reasons for the collection of my or my child's 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 or my child's 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 for my child 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 my child experiences pain or discomfort or I am uncomfortable with anything during the session, I will immediately inform my therapist. I will not hold my therapist responsible for any pain or discomfort my child experiences 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 my child is participating in these session to bring about a better learning potential. Any mental, physical or emotional changes my child experiences are a result of my child's ability to learn to change.
- 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 child's 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