



Client History

Name:

Date of Birth:

Contact Details

Address		Email	
Postcode			
Caregivers' Names		Contact Phone Numbers	
Allergies, intolerances or sensitivities	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Neck or Back injuries	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Seizure disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diagnoses	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details:
Past or current other therapies & therapists			
What are the challenges that bring you here today?			
Emergency Contact Person & Contact Details			

Pregnancy/Birth Details

Birth weight			
Born at Term	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If No, at what week?
Caesarean	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Particularly fast delivery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Particularly slow delivery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
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 <input type="checkbox"/>	Yes <input type="checkbox"/>
Periods of serious or recurrent illness	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Strong reaction to vaccination	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Began to speak after 18mths	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Difficulties with sleep. A lot of screaming.	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Strikingly sluggish or inactive	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Feeding Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Frequent ear infections	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Army Crawled	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Crawled on hands and knees	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Bum shuffled	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Rolled	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Did one leg trail behind when crawling	No <input type="checkbox"/>	Yes <input type="checkbox"/>

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 <input type="checkbox"/>	Yes <input type="checkbox"/>	Normal <input type="checkbox"/>	Marked <input type="checkbox"/>	Slight <input type="checkbox"/>
Bed-wetter after the age of 5	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Is your child coping with school generally?	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Struggles to sit still	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Fear of the dark	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Anxious	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Dominant hand shown	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Left <input type="checkbox"/>	Right <input type="checkbox"/>	
Motion Sickness	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Slouches over table when writing	No <input type="checkbox"/>	Yes <input type="checkbox"/>			

Easily disturbed/distracted	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Mouth movements when writing	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Toewalks	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Falls or trips often	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Poor endurance and stamina	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Shy, problems asserting oneself	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Impulsive	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Fits of emotion	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Has good ideas but can't put them into writing	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Turns page on angle when writing	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Poor Memory	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Chews or sucks pens, fingernails or other objects, fingers or clothes	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Messy eater	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Frequent mood swings	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Difficulty accepting criticism	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Inflexible and needs routine	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Procrastinates	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Craves sweet food	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Difficulty with:		
<ul style="list-style-type: none"> Making friends/playing with other children/easily gets into conflict 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> Throwing a ball 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> Kicking a ball 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> Reading 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> Spelling 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> Handwriting 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Sleep	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> settling to sleep 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> waking during the night 	No <input type="checkbox"/>	Yes <input type="checkbox"/>
<ul style="list-style-type: none"> What time do they usually go to sleep at night? 		
<ul style="list-style-type: none"> What time do they naturally wake? 		

Vision concerns	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Speech concerns	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Hypersensitivities	No <input type="checkbox"/>	Yes <input type="checkbox"/>

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)

NDIS Clients:

NDIS #: _____ NDIS Plan Dates: _____

I am Self-managed Plan- managed

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