Confidential Patient Health Record (*Child*) ***Today's Date:*** ____/____/______

Child's Name______________________________Date of birth _____________ Age________

Parent(s) Names____

Address ____ Apt # ____________

City ____ State _______ ZIP ______________

Home Phone (______) ______________________ Work Phone (______) ________________

E-mail address_____________________________Best way to reach you:_________________

Referred by____

Please provide details if any or all of the following applies to this client: ☐ was adopted
Lives with: ☐ Mother ☐ Father ☐ Both ☐ Stepparent ☐ Legal guardian ☐ Other__________

Name of Sibling(s)	Age	Sex	Any difficulty in sibling relationship?
________________________	______	M / F	________________________________
________________________	______	M / F	________________________________
________________________	______	M / F	________________________________

OVERALL HEALTH (circle one): Excellent / Good / Fair / Poor / Other: ________________

Reason child is here: ____

____

____

____

Previous Treatments for this complaint ____

____

____

____

Other complaints or problems: (*use a separate sheet if needed*) ___________________________

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BOSTON Brain INTEGRATION

Medical History

The following questions are part of the background necessary to evaluate your child's brain processing. A number of factors involved with the prenatal, birth and early postnatal periods are sometimes associated with learning and emotional difficulties. Please briefly indicate if any of the listed items below apply and note any that are not included in this list.

1. Child's Mother:

   Sickness of any kind. *Describe*____

   Anything requiring medical attention of any kind during or as a result of pregnancy or birth. *Describe*____

2. Child's birth:

   Any difficulty in the birthing process? ______________________________

   Foetal distress at birth? ______________________________

   Was there a period of extended separation after birth, e.g. premature? ____________

   Medical treatment of any kind needed? ______________________________

   Any other problems?______________________________

3. Is your child currently under the care of a physician, therapist, or other health care professional? (if yes, please list name(s) and date(s) of last visit): __________________

4. Current medications/drugs being taken: ______________________________

5. Nutritional supplements child is currently taking: ______________________________

6. Does your child suffer from Asthma?__________Is he/she taking medication for it? _________
   Which medication and how often?______________________________

7. Any household pets or other animals your child is in close contact with:__________________

8. Has your child ever had a problem abusing substances?_______Does he/she smoke?_________
   Does he/she drink alcohol?_______Do drugs?________Please list any concerns you may have about your child and substance abuse: ______________________________

BOSTON Brain INTEGRATION

9. Has your child suffered any serious childhood diseases, had any operations, or had other medical problems? ____
____
____

10. Has your child ever been knocked unconscious? ______ If yes, for how long and under what circumstances? ____
____
____

11. Has your child ever been in a car accident?_____If yes, did he/she get whip lash? Please describe____
____

12. Has your child ever had an epileptic fit? _____ If yes, please describe____________________
____

13. Has your child ever suffered Febrile Seizures (high temperature induced fits or seizures), especially between 18 months and 3 years? ______ If yes, please describe_______________
____

14. When did your child start to crawl? ___________Did he/she crawl normally – opposite hand and knee – or did he/she tend to scoot along on his/her bum or drag/extend one leg? Please describe____

15. When did your child start talking? _________Was there any verbal language delay?_______ If so, how long?____

16. How would you describe your child's mood on a day-to-day basis? _____________________
____
____

17. Does your child have any history of mental illness? _________If yes, please describe_______
____
____

18. Please list any other facts or information about your child that you feel are relevant!_______
____
____
____
____
____
____

Boston Brain
Integration

Does your child suffer from any of these conditions?

Head injuries	**Speech issues**	**Mood issues**
☐ Head injury (loss of consciousness) ☐ Head injury (no loss of consciousness) ☐ Motor vehicle accident ☐ Fall (severe) ☐ Other_____________	☐ Lisp ☐ Stuttering ☐ Slurred speech ☐ Difficulty finding words ☐ Hoarseness ☐ TMJ problems ☐ Slow to begin speaking ☐ Other_____________	☐ Anxiety ☐ Depression ☐ Mood swings ☐ Bi-polar disorder ☐ Suicidal thoughts ☐ Excessive appetite ☐ Loss or change in appetite ☐ Other_____________
Eye problems ☐ Wear glasses/contacts ☐ Wear reading glasses ☐ Lazy eye ☐ Other_____________	**Hearing difficulty** ☐ Hearing loss ☐ Headaches ☐ Migraines ☐ Other_____________	**Balance problems** ☐ Dizziness ☐ Vertigo ☐ Unsteadiness of gait ☐ Loss of balance ☐ Other_____________
Brain issues ☐ Seizures ☐ Loss of memory ☐ Strokes ☐ Confusion ☐ Other_____________	**Sleep problems** ☐ Sleep apnea ☐ Nightmares ☐ Insomnia ☐ Other_____________	**Breathing difficulties** ☐ Asthma ☐ Shortness of breath ☐ Other_____________
Problems in childhood ☐ Bedwetting ☐ Bullying/being bullied ☐ Other_____________	**Allergy** ☐ Anaphalaxis ☐ Food intolerance ☐ Nasal congestion ☐ Itchy skin ☐ Rash ☐ Sneezing ☐ Other_____________	

Disclaimer

I understand the Brain Integration practitioner does not diagnose illness, disease, or any other physical or mental disorder. As such, the Brain Integration practitioner prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations or psychological counseling. It is clear to me that Brain Integration, kinesiology, and related energy work are not substitutions for medical examinations and/or diagnosis.

I take responsibility for alerting the therapist to any physical conditions or prescribed medications that would affect this work. I understand that my Brain Integration treatment and patient record will be held strictly confidential in accordance with HIPAA.

I understand that payment is due on date of rendered service. I also understand that a minimum of ***24 hours' notice*** *is expected if the need to cancel an appointment arises, otherwise I will be billed for the full appointment.*

I declare that the above information is correct to the best of my knowledge:

Signed:____ Date:______________