



BOSTON *Brain*
INTEGRATION

Confidential Patient Health Record

Today's Date: _____ / _____ / _____

Name _____ Date of birth _____ Age _____

Address _____ Apt # _____

City _____ State _____ ZIP _____

Home Phone (_____) _____ Work Phone (_____) _____

E-mail address _____ Best way to reach you: _____

Referred by _____

Occupation _____ Employer _____

Marital Status: S M D W Name of Spouse _____

Name of Child/Sibling Age Sex Any concerns? *(Use separate sheet if needed)*

_____ M / F _____

_____ M / F _____

_____ M / F _____

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 _____

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

Reason you are here: _____

Previous Treatments for this complaint _____

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

Medical History

The following questions are part of the background necessary to evaluate your brain processing. A number of factors involved with the prenatal, birth and early postnatal periods are sometimes associated with learning and emotional difficulties. Any information you know about your early life will be helpful.

1. Your Mother:

Sickness of any kind. *Describe* _____

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

2. Client's birth:

Any difficulty in the birthing process? _____

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

Medical treatment of any kind needed? _____

Any other problems? _____

3. Are you 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 you are taking: _____

6. Does you suffer from Asthma? _____ Are you taking medication for it? _____
Which medication and how often? _____

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

8. Do you smoke, drink alcohol, or consume any other substances? (if yes, indicate how much)
Cigarettes _____ *Alcohol* _____ *Other Substances* _____

9. Have you suffered any serious childhood diseases, had any operations, or other medical problems? _____

10. Have you ever been knocked unconscious? _____ If yes, for how long and under what circumstances? _____

11. Have you ever been in a car accident? _____ If yes, did they get whip lash? Please describe _____

12. Have you ever had an epileptic fit? _____ If yes, describe _____

13. Have you ever suffered Febrile Seizures (high temperature induced fits or seizures), especially between 18 months and 3 years? _____ If yes, describe _____

14. When did you start to crawl? _____ Did you crawl normally – opposite hand and knee – or did you tend to scoot along on your bums or drag/extend one leg? _____

15. When did you start talking? _____ Was there any verbal language delay? _____
If so, how long? _____
16. How would you describe your mood on a day-to-day basis? _____

17. Any other facts or information that you feel are relevant? _____

Do you suffer from any of these conditions?

<p>Head injuries</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head injury (loss of consciousness) <input type="checkbox"/> Head injury (no loss of consciousness) <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Fall (severe) <input type="checkbox"/> Other _____ 	<p>Speech issues</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lisp <input type="checkbox"/> Stuttering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Difficulty finding words <input type="checkbox"/> Hoarseness <input type="checkbox"/> TMJ problems <input type="checkbox"/> Slow to begin speaking <input type="checkbox"/> Other _____ 	<p>Mood issues</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Bi-polar disorder <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Loss or change in appetite <input type="checkbox"/> Other _____
<p>Eye problems</p> <ul style="list-style-type: none"> <input type="checkbox"/> Wear glasses/contacts <input type="checkbox"/> Wear reading glasses <input type="checkbox"/> Lazy eye <input type="checkbox"/> Other _____ 	<p>Hearing difficulty</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Other _____ 	<p>Balance problems</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo <input type="checkbox"/> Unsteadiness of gait <input type="checkbox"/> Loss of balance <input type="checkbox"/> Other _____
<p>Brain issues</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Loss of memory <input type="checkbox"/> Strokes <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____ 	<p>Sleep problems</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Nightmares <input type="checkbox"/> Insomnia <input type="checkbox"/> Other _____ 	<p>Breathing difficulties</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other _____
<p>Problems in childhood</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bedwetting <input type="checkbox"/> Bullying/being bullied <input type="checkbox"/> Other _____ 	<p>Allergy</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anaphalaxis <input type="checkbox"/> Food intolerance <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Itchy skin <input type="checkbox"/> Rash <input type="checkbox"/> Sneezing <input type="checkbox"/> 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: _____