wholebody solutions

nutrition • chiropractic • acupuncture • 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	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) _____

_____

_____

_____

wholebody solutions

nutrition • chiropractic • acupuncture • brain integration

Medical History

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

1. 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? (e.g. cord around neck, posterior presentation, foetal distress, forceps, oxygen problems at birth, baby bluish)_____
- ☐ Foetal distress at birth? _____
- ☐ Was your baby removed for a period before presentation to you? _____

  If yes, for how long_____
- ☐ Was there a period of extended separation, 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. Do you smoke, drink alcohol, or consume any other substances? (if yes, indicate how much)

wholebody solutions

nutrition • chiropractic • acupuncture • brain integration

Cigarettes _____ *Alcohol* _____ *Other Substances* _____

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

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

9. Have you ever been in a car accident?_____If yes, did they get whip lash? Please describe_____
_____

10. Have you ever had an epileptic fit? _____ If yes, describe_____
_____

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

12. Do you suffer from Asthma?_____Taking medication for it? _____
Which and how often?_____

13. 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?_____
_____

14. When did you start talking? _____Was there any verbal language delay?_____ If so, how long? _____

15. Any household pets or other animals you or family members are in close contact with:_____
_____

16. How would you describe your mood on a day-to-day basis? _____
_____
_____
_____

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

wholebody solutions

nutrition • chiropractic • acupuncture • brain integration

Do you suffer from any of these conditions?

Head injuries ☐ Head injury (loss of consciousness) ☐ Head injury (no loss of consciousness) ☐ Motor vehicle accident ☐ Fall (severe) ☐ Other_____	**Speech issues** ☐ Lisp ☐ Stuttering ☐ Slurred speech ☐ Difficulty finding words ☐ Hoarseness ☐ TMJ problems ☐ Slow to begin speaking ☐ Other_____	**Mood issues** ☐ 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_____	

wholebody solutions

nutrition • chiropractic • acupuncture • brain integration

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:_____