



**MNRI® MINI CLINIC-GUELPH *MEDICAL FORM***

**Dear Parent/Guardian/Client:** In order for your child (or adult participant) to attend the MNRI® Mini Clinic this form must be filled out **completely** and returned along with a photocopy of medical insurance coverage for Canada for duration of your stay or a copy of OHIP card for Canadian residents.

**Mini Clinic Date:** April 14-16, 2010      **Mini Clinic Location:** Staybridge Suites, 11 Corporate Crt, Guelph Ontario, N1G 5G5

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***Registrant Information (Complete in Full / Please Print/Use ink):***

Full name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Complete mailing address: \_\_\_\_\_

\_\_\_\_\_ Postal/zip code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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***Parent/Guardian Information:***

Full name: \_\_\_\_\_

Relationship to Registrant: \_\_\_\_\_

Complete mailing address (*necessary only if different than registrant*):

\_\_\_\_\_

\_\_\_\_\_ Postal/zip code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Parent/Guardian's Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*Please staple a photocopy of insurance card (front and back of card) to medical form.*

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**Emergency Contact Information:**

Full name: \_\_\_\_\_

Relationship to Registrant: \_\_\_\_\_

Complete mailing address (*necessary only if different than registrant*):

\_\_\_\_\_  
\_\_\_\_\_

Postal/zip code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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**Medical History:**

Please check box next to each medical problem listed below that registrant has experienced/or is currently experiencing:

- |                                                                                                     |                                                   |                                                        |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Allergies                                                                  | <input type="checkbox"/> Head Injury/Trauma       | <input type="checkbox"/> Pneumonia                     |
| <input type="checkbox"/> Ankle sprains & Knee injuries                                              | <input type="checkbox"/> Heart problems or murmur | <input type="checkbox"/> Rheumatic fever               |
| <input type="checkbox"/> Asthma                                                                     | <input type="checkbox"/> Hernia                   | <input type="checkbox"/> Rubella                       |
| <input type="checkbox"/> Back problems                                                              | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Cancer                                                                     | <input type="checkbox"/> Head Injury              | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Chest pain <input type="checkbox"/> Mild <input type="checkbox"/> Severe   | <input type="checkbox"/> Hypoglycemia             | <input type="checkbox"/> Sickle cell anemia            |
| <input type="checkbox"/> Chicken pox                                                                | <input type="checkbox"/> Insomnia                 | <input type="checkbox"/> Sinusitis                     |
| <input type="checkbox"/> Chronic pain <input type="checkbox"/> Mild <input type="checkbox"/> Severe | <input type="checkbox"/> Jaundice, liver disease  | <input type="checkbox"/> Sleep problems/walking        |
| <input type="checkbox"/> Diabetes                                                                   | <input type="checkbox"/> Joint problems           | <input type="checkbox"/> Stomach, intestinal trouble   |
| <input type="checkbox"/> Ear trouble/Hearing Loss                                                   | <input type="checkbox"/> Kidney, bladder problems | <input type="checkbox"/> Tension                       |
| <input type="checkbox"/> Eye trouble/Vision Loss                                                    | <input type="checkbox"/> Measles                  | <input type="checkbox"/> Throat problems               |
| <input type="checkbox"/> Fainting                                                                   | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Thyroid problems              |
| <input type="checkbox"/> Gall bladder trouble                                                       | <input type="checkbox"/> Neurological disorder    | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Frequent headaches                                                         | <input type="checkbox"/> Palpitations             | <input type="checkbox"/> Other                         |

**FEMALES ONLY:**

- Irregular periods       Severe cramps       Excessive flow

Please provide additional explanation for each checked medical problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Medical History:** (continued)

Please check the box next to each developmental issue registrant has experienced/or is currently experiencing:

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|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Attention deficit Disorder                                   | <input type="checkbox"/> Epilepsy/Seizure Disorder                                       |
| <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder                     | <input type="checkbox"/> Fine Motor Delay (not related to underlying medical condition)  |
| <input type="checkbox"/> Apraxia/Articulation Disorder/Dysarthria                     | <input type="checkbox"/> Gross Motor Delay (not related to underlying medical condition) |
| <input type="checkbox"/> Auditory Processing Disorder                                 | <input type="checkbox"/> Hearing Impairment                                              |
| <input type="checkbox"/> Generalized Anxiety Disorder                                 | <input type="checkbox"/> Cochlear Implant                                                |
| <input type="checkbox"/> Attachment Disorder                                          | <input type="checkbox"/> Hearing Aid                                                     |
| <input type="checkbox"/> Autism Spectrum Disorder                                     | <input type="checkbox"/> Language Disorder                                               |
| <input type="checkbox"/> Asperger's Syndrome                                          | <input type="checkbox"/> Expressive Language Delay                                       |
| <input type="checkbox"/> Pervasive Developmental Disorder                             | <input type="checkbox"/> Receptive Language Delay                                        |
| <input type="checkbox"/> Bipolar Disorder                                             | <input type="checkbox"/> Mixed Expressive/Receptive                                      |
| <input type="checkbox"/> Cerebral Palsy                                               | <input type="checkbox"/> Stuttering                                                      |
| <input type="checkbox"/> Has functional movement of lower extremities                 | <input type="checkbox"/> Obsessive Compulsive Disorder                                   |
| <input type="checkbox"/> Has functional movement of upper extremities                 | <input type="checkbox"/> Oppositional Defiance Disorder                                  |
| <input type="checkbox"/> Cerebral Vascular Accident                                   | <input type="checkbox"/> Rett's Syndrome                                                 |
| <input type="checkbox"/> Congenital Abnormality                                       | <input type="checkbox"/> Sensory Integration Dysfunction                                 |
| eg. Club Foot, Cleft Lip/Palate, etc., Please list: _____                             | <input type="checkbox"/> Schizophrenia                                                   |
|                                                                                       | <input type="checkbox"/> Tic disorder/Tourettes                                          |
| <input type="checkbox"/> Depression                                                   | <input type="checkbox"/> Traumatic Brain Injury                                          |
| <input type="checkbox"/> Downs Syndrome                                               | <input type="checkbox"/> Vision Impairment. Please indicate degree of impairment: _____  |
| <input type="checkbox"/> Eating/Feeding Disorder                                      | <input type="checkbox"/> Visual Processing Disorder                                      |
| <input type="checkbox"/> Developmental Delay                                          | <input type="checkbox"/> Other diagnosis/es not included in list: _____                  |
| <input type="checkbox"/> Dyslexia                                                     | _____                                                                                    |
| <input type="checkbox"/> Dysgraphia                                                   | _____                                                                                    |
| <input type="checkbox"/> Dyscalculia                                                  | _____                                                                                    |
| <input type="checkbox"/> My child does not have any formal diagnosis/es at this time. |                                                                                          |

Please provide additional explanation for each checked medical problem: \_\_\_\_\_

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Please provide any additional information that may be useful for therapists to understand while working with your child at the Mini Clinic-Guelph: \_\_\_\_\_

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**Medical History:** (continued)

Does the registrant have any other serious medical problems, or been under physicians care recently?

Yes: \_\_\_\_ No: \_\_\_\_ If yes, please explain: \_\_\_\_\_

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Has the registrant received all the required immunizations? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If no, please explain: \_\_\_\_\_

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Date of Last Tetanus Shot? \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Allergies & Dietary Restrictions:**

Does the registrant have any food, environmental, medication or other allergies? Yes: \_\_\_\_ No: \_\_\_\_

If yes, please list allergens and explain: \_\_\_\_\_

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Does the registrant have any Diet Restrictions? Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, please list allergens and explain: \_\_\_\_\_

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**Medications:**

All medications must be in original pharmacy container. The parent/guardian/adult registrant is responsible for all medications. The MNRI<sup>®</sup> Mini Clinic Guelph is not responsible for administering any medications at any time.

List all of registrant's medications (what), include dosage (how much) and daily schedule (when):

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**Therapy/Intervention History:**

Intervention	Please check box if therapy used "Currently" or "In Past"		Please indicate how long therapy has been/was used and if discontinued, how long ago.		Please indicate how often therapy is/was used?		
	Therapy currently ongoing	Therapy used in past	Months &/or years therapy has been used?	How long ago was therapy discontinued	Times/Week or	Times/Month or	Times/Year
Masgutova Neurosensorimotor Reflex Integration							
Academic Support/Tutoring							
Accupuncture							
Applied Behavioral Analysis (ABA)							
Auditory Listening Therapy							
Biofeedback							
Chiropractic Care							
Feldenkrais Therapy							
Hippo Therapy							
Massage Therapy							
Music Therapy							
Neurotherapy							
Occupational Therapy							
Physical Therapy							
Psychologist/Psychiatrist • Cognitive Behavioral Therapy • Psychotherapy • Other: _____							
Speech Therapy							
Vision Therapy							
Other: _____							

Other: _____							
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***Acknowledgement of MNRI® Medical Form Truthfulness:***

I declare that the answers/statements I have provided in the MNRI™ Family Conference Medical Form are accurate, complete and true to the best of my knowledge and belief.

**Signature of Adult/Guardian/Adult Registrant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Required Return Date for MNRI® Mini Clinic Medical Form and attached proof of medical insurance coverage for Canada for duration of your stay or copy of OHIP card for Canadian residents) :***

Please return *form* no later than two weeks prior to the beginning of the MNRI® Mini Clinic. *Please note, registrant will not be able to participate in conference without submission of completed form.*

**Purchase of Manual:**

I wish to purchase \_\_\_\_\_ copies of *Integration of Infant Dynamic and Postural Reflex Patterns: Neurosensorimotor and Reflex Integration Method for Children and Adults. 2007 Ed. @ \$74.00 each. Please bring payment with you at time for your child’s appointment.*