



383 W. Drake Rd., Suite 201, Fort Collins CO 80526
www.OpenPathways.org Info@OpenPathways.org 970-416-6330

NEW CLIENT INFORMATION

Client Name _____

Parents (if client is child) _____

Date of Birth _____ Age _____ Grade in school (if applicable) _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Bus. # _____ Cell # _____

Email address _____ Referred by _____

May we contact this person to thank them? _____

Brief description of the concerns that brought you here:

What improvement or changes do you hope to see?

I hereby declare that the information in this multi-page **New Client Packet** is correct to the best of my knowledge. I further understand that I am responsible to pay for my scheduled appointment in full on the date such service is rendered. **If I miss an appointment without giving 24 hour notification, I understand I will be billed the full hourly rate** (whether that appointment is prepaid or paid hourly) – except for approved emergencies.

Signed _____ Date _____

Open Pathways to Learning - Behavioral Check List

NAME _____

DATE _____

Please check anything that **might** apply, placing **two checks** along side anything that is especially important or prevalent.

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Accident prone <input type="checkbox"/> Allergies (feel tired or hyperactive after eating) <input type="checkbox"/> Clumsy <input type="checkbox"/> Constipated <input type="checkbox"/> Daydreams excessively • <input type="checkbox"/> Difficulty budgeting time • <input type="checkbox"/> Difficulty concentrating • <input type="checkbox"/> Difficulty focusing eyes • <input type="checkbox"/> Difficulty following directions • <input type="checkbox"/> Difficulty giving directions • <input type="checkbox"/> Difficulty telling time • <input type="checkbox"/> Dizziness, vertigo, balance problems <input type="checkbox"/> Eye strain/ rubs eyes a lot <input type="checkbox"/> Fear of speaking in front of a group <input type="checkbox"/> Trouble remembering directions <input type="checkbox"/> Trouble remembering months of the year <input type="checkbox"/> Trouble remembering names • <input type="checkbox"/> Trouble remembering right/left <input type="checkbox"/> Trouble remembering times tables • <input type="checkbox"/> Trouble differentiating colors <input type="checkbox"/> Headaches <input type="checkbox"/> Impatient/ restless • <input type="checkbox"/> Impulsive • <input type="checkbox"/> Inappropriate drowsiness <input type="checkbox"/> Lacks confidence • <input type="checkbox"/> Leaves projects incomplete • <input type="checkbox"/> Letter/number reversal <input type="checkbox"/> Lies • <input type="checkbox"/> Mood swings • <input type="checkbox"/> Over/under active (circle which) • <input type="checkbox"/> Poor eye-hand coordination <input type="checkbox"/> Poor handwriting <input type="checkbox"/> Poor organizational skills • <input type="checkbox"/> Poor reading comprehension • <input type="checkbox"/> Poor reading skills <input type="checkbox"/> Poor physical balance | <ul style="list-style-type: none"> <input type="checkbox"/> Poor arithmetic skills <input type="checkbox"/> Poor spelling • <input type="checkbox"/> Poor at sports or rhythmic activities <input type="checkbox"/> Rests head on arm while working • <input type="checkbox"/> Short attention span • <input type="checkbox"/> Slow in completing work • <input type="checkbox"/> Stops in the middle of a game • <input type="checkbox"/> Forgets to turn in schoolwork <input type="checkbox"/> Test or performance anxiety <input type="checkbox"/> Timid or shy • <input type="checkbox"/> Poor at reading social cues <input type="checkbox"/> Compulsiveness <input type="checkbox"/> Defiant/oppositional <input type="checkbox"/> Picky eater <input type="checkbox"/> Sensitive to sound <input type="checkbox"/> Issues with clothing, tags, socks, etc. <input type="checkbox"/> Difficulty falling asleep at night <input type="checkbox"/> Sensitive to smells <input type="checkbox"/> Sugar cravings <input type="checkbox"/> Bread/carbohydrate cravings <input type="checkbox"/> Eats a poor diet <input type="checkbox"/> Under/over eats <input type="checkbox"/> Phobias/fears (explain) • <hr/> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Speech difficulties (explain) <hr/> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> History of other therapies such as physical, vision, occupational, etc. Please list them below: <hr/> <hr/> <hr/> |
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**MEDICAL HISTORY FOR BRAIN INTEGRATION
ADULT FORM**

Your response to the following questions will assist us in our evaluation of your needs. A variety of these factors can sometimes be associated with learning difficulties. Please fill in this questionnaire to the best of your knowledge. If a comment is requested, a brief response will be helpful.

Were there any complications at birth, C- Section, breech, loss of oxygen, etc? _____

Did you suffer from any childhood diseases, chicken pox, polio, small pox, high fevers, etc.? _____

Were you ever hospitalized as a child? Explain _____

Do you suffer from any of the following allergies?

- Pollen
- House dust, dust mites
- Food colorings, preservatives, dyes
- Chemicals, gasoline fumes, perfumes
- Foods _____
- Other _____

Do you suffer from asthma? _____ Taking medication? _____

Which and how often? _____

Are you currently under a doctor/health professional's care? ____ If so for what conditions?

Are you taking any other medications/supplements? Which ones and for what conditions?

Have you ever been knocked unconscious? _____ If yes, what happened and for how long?

Have you ever had seizures? _____ Explain _____

Did you have a positive school experience growing up? _____

Did you receive any special services in school, e.g. speech therapy, physical therapy, special ed, etc?

Please note any other info that you think would be relevant. Feel free to use back side if you wish.

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INFORMED CONSENT STATEMENT

I, _____, hereby attest and agree to the following:

1. I understand that the practitioners of Open Pathways to Learning are certified in Crossinology Brain Integration Technique and are not licensed physicians and cannot diagnose disease, prescribe drugs or recommend treatments for specific diseases.
2. I understand that the practitioners of Open Pathways to Learning and their representatives do not claim or imply that with any advice, counsel, suggestions, recommendations or services that they may provide whether in person, by mail, by e-mail or by telephone will cure, treat, prevent or mitigate any disease condition.
3. I certify that the practitioners of Open Pathways to Learning and their representatives have not suggested that I cease any medical care I may now be undertaking. I further state that the decisions I make regarding my health care or the health care of those under my guardianship are my responsibility and that I will not hold Open Pathways to Learning or its agents responsible or accountable for any consequences of my decisions.

I have read and understand the foregoing and agree to the terms and conditions as stated.

Dated this _____ day of _____, 20_____

Client's signature or parent if client is under 18



Consent Form for the Release of Information

Open Pathways to Learning has given you this form because we have requested your consent to allow us to release information regarding your own or your child's treatment. Your consent allows us to engage in the professional communications that helps us provide you or your child the best possible support.

Please carefully review the following statements. If you agree with them, please sign in the space indicated. This consent form can be signed only by the person to whom the information or record applies, or by the parent or legal guardian of a minor to whom this information applies. Thank you.

- ⇒ I understand that this consent is voluntary and that I can revoke it at any time by communicating that in writing to Open Pathways.
- ⇒ I hereby give Open Pathways permission to share the information it deems necessary about its treatment to _____ (fill in full name of client) with various healthcare professionals, therapists, teachers, tutors, etc.
- ⇒ Open Pathways treats all client related information and records as confidential. We will discuss or release client information only in a manner that supports our own ability to better serve our clients and supports the ability of other care providers to serve the clients we hold in common.

I acknowledge with my signature below that I am the individual to whom the information or record applies or that I am that parent or legal guardian if the client is a minor.

Your Name Printed:

Your Signature:

Date of Signature:

Your Relationship to Client (if other than yourself):

Name of person we can release information to:

Their practice or Institution:

Phone #:

Email:

Address:

OPEN PATHWAYS TO LEARNING LLC APPOINTMENT AND PAYMENT POLICIES

We're pleased you've decided to invite our practice to serve you and your family. We take our responsibilities to you seriously and promise to do everything in our power to serve you professionally and responsibly. We encourage you to give us feedback if there is anything we can ever do to better meet your needs.

In turn, we ask that you work with us to help our practice run smoothly by agreeing to our Appointment and Payment Policies. Failure to provide adequate notice if you must miss an appointment negatively impacts your practitioner by creating a gap in her schedule, as well as affects other clients who could have scheduled an appointment had proper notice been given.

Regarding Cancellations and No-Shows for Scheduled Appointments:

- If you must cancel an appointment, please phone or email our office at **least 24 hours prior to that appointment**. Failure to do so will result in your being charged the **full fee** for that missed time unless we are able to find another client to take your spot.
- Please inform us of your need to cancel appointments as early as possible, even a week or more ahead, to help us accommodate the scheduling needs of other families. *Thank you!*
- We will consider making exceptions to charging for cancelled or missed appointments on a case-by-case basis for genuine emergencies such as sudden illness.
- A repetitive pattern of canceling or missing appointments may result in your regularly scheduled time slot being given to another client. When school is in session we have a waiting list for clients desiring mid and late afternoon appointments.

Regarding Payment for Treatment:

- Payment is due at the time of treatment. You may pay with cash, check (payable to Open Pathways), or credit card (VISA or MasterCard).
- In order to provide you the maximum treatment time and to help keep appointments on time, please have your check made out in advance of treatment.

I have read, understand, and agree to the above policies:

Client Signature _____ Date _____

**WHOLE-BODY SOLUTIONS TO
LEARNING & BRAIN DYSFUNCTIONS**