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.

- ☐ Accident prone
- ☐ Allergies (feel tired or hyperactive after eating)
- ☐ Clumsy
- ☐ Constipated
- ☐ Daydreams excessively •
- ☐ Difficulty budgeting time •
- ☐ Difficulty concentrating •
- ☐ Difficulty focusing eyes •
- ☐ Difficulty following directions •
- ☐ Difficulty giving directions •
- ☐ Difficulty telling time •
- ☐ Dizziness, vertigo, balance problems
- ☐ Eye strain/ rubs eyes a lot
- ☐ Fear of speaking in front of a group
- ☐ Trouble remembering directions
- ☐ Trouble remembering months of the year
- ☐ Trouble remembering names •
- ☐ Trouble remembering right/left
- ☐ Trouble remembering times tables •
- ☐ Trouble differentiating colors
- ☐ Headaches
- ☐ Impatient/ restless •
- ☐ Impulsive •
- ☐ Inappropriate drowsiness
- ☐ Lacks confidence •
- ☐ Leaves projects incomplete •
- ☐ Letter/number reversal
- ☐ Lies •
- ☐ Mood swings •
- ☐ Over/under active (circle which) •
- ☐ Poor eye-hand coordination
- ☐ Poor handwriting
- ☐ Poor organizational skills •
- ☐ Poor reading comprehension •
- ☐ Poor reading skills
- ☐ Poor physical balance
- ☐ Poor arithmetic skills
- ☐ Poor spelling •
- ☐ Poor at sports or rhythmic activities
- ☐ Rests head on arm while working •
- ☐ Short attention span •
- ☐ Slow in completing work •
- ☐ Stops in the middle of a game •
- ☐ Forgets to turn in schoolwork
- ☐ Test or performance anxiety
- ☐ Timid or shy •
- ☐ Poor at reading social cues
- ☐ Compulsiveness
- ☐ Defiant/oppositional
- ☐ Picky eater
- ☐ Sensitive to sound
- ☐ Issues with clothing, tags, socks, etc.
- ☐ Difficulty falling asleep at night
- ☐ Sensitive to smells
- ☐ Sugar cravings
- ☐ Bread/carbohydrate cravings
- ☐ Eats a poor diet
- ☐ Under/over eats
- ☐ Phobias/fears (explain) •

____

____

- ☐ Speech difficulties (explain)

____

____

- ☐ History of other therapies such as physical, vision, occupational, etc. Please list them below:

____

____

____

____

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MEDICAL HISTORY FOR BRAIN INTEGRATION
CHILD FORM

Your responses to the following questions will help us evaluate your child's learning problems. A number of the factors listed below can sometimes be associated with learning difficulties in children. Please fill out this questionnaire as completely as possible. If it asks for a comment, a brief explanation will be helpful.

Care of mother before birth:

____ Sickness of any kind, please describe ____
____ Toxemia, describe ____
____ Accidents e.g. falls, etc., describe ____
____ Anything requiring medical attention, of any kind, during pregnancy
Describe____
____ Any drugs taken or prescribe, list: ____
____ Other, describe ____

Child's birth:

Was birth premature? ____
How long was labor? ____
Any drugs used during labor? ____
Oxygen problems at birth, i.e. cord around the neck, baby bluish in color, etc.?
____
Fetal distress at birth? ____
Caesarean? ________ Any problems? ____
Was the delivery rapid? ____
Forceps used? ________ The location of any marks on the head immediately after birth, indicate which: ___ High- above ears ___ Mid- level with ears ___ Low-below ears
Was there a period of extended separation, e.g. premature? ____________________________
Any difficulty with the birth or post-natal? ____
Medical treatment for baby of any kind needed? Please describe ________________________
____
Any other problems? ____
____

Childhood:

Has your child suffered from any serious childhood diseases, had any operations, or other medical problems? Briefly describe ____
____
Has your child had the routine vaccinations? ____
Any additional ones? ____
Were there any reactions?____
Has your child ever had ear infections? ____
Does your child have any allergies that you are aware of? ____________________________

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

Is your child currently under a doctor's or health professional's care? For what conditions, if so?
____
____

Taking any medications/supplements? Which ones and for what conditions?________________
____
____

Has your child ever been knocked unconscious? ______ If yes, for how long and what happened?
____

Has your child ever had an epileptic fit? ________ If yes, describe ________________________
____

Has your child ever had Febrile Seizures (high temperature induced fits or seizures,) especially between 18 months and 3 years? ______ If yes, describe _________________________________
____

Does your child suffer from asthma? __________ Taking medication? _____________________
Which and how often? ____
Has your child been diagnosed with any medical conditions not covered here? _______________
____

Development:

Did your child crawl? ___________ At what age? ______________

When did your child start talking? ____________ Were there any language delays? __________
If so how long? ____

Does your child receive special education services in school? ________ If so for what?
____

Has your child's teacher's expressed any concerns about your child's learning? ______________
____
____

Any other information that you think would be relevant:

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____

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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