Thrive Comm*Unity* Acupuncture & Massage

110 W. Harvard St., Fort Collins CO 80525
www.BeWellandThrive.org Info@BeWellandThrive.org 970-282-8300

New Client Information

Client Name _____

Parents (if client is child) _____

Date of Birth _____ Age____ Grade in school _____ Name of School _____

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 _____

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

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 or your child suffer from any childhood diseases, chicken pox, polio, small pox, high fever?

_____

_____

Were you or your child ever hospitalized as a child? Explain

_____

_____

Do you or your child suffer from any of the following allergies?

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

Do you or your child 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 Nancy Evans is not a licensed physicians and cannot diagnose disease, prescribe drugs or recommend treatments for specific diseases.

2. I understand that Nancy Evans does 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 Nancy Evans 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 Nancy Evans 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