Hope in Healing Counseling and Wellness, LLC
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Client Registration

Date:_____

Name:_____ DOB:_____ Age:_____

Address:_____

City:_____ State:_____Zip:_____

Primary Phone: (_____)_____ Can I leave messages/text on this phone? □ Yes □ No

Secondary Phone: (_____)_____ Can I leave messages/text on this phone? □ Yes □ No

E-mail:_____ May I email you? □ Yes □ No

What is the best way to get a hold of you?_____ What is the best time to get a hold of you? _____

Emergency Contacts

Emergency Contact:_____Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:(_____)_____ Secondary Phone:(_____)_____

In case of an emergency, I grant permission to contact my emergency contact? □ Yes □ No

In case of an emergency, I grant permission to leave a message? □ Yes □ No

How did you hear about Hope in Healing Counseling and Wellness, LLC?_____

_____

Name of Person Referring: _____

□Physician □Therapist □Friend □Relative □Co-Worker □Other_____

Client Signature: _____Date:_____