

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 with my emergency contact? 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: _____