Terri Anderson LMT, CIMI
(503) 348-4794

Client Registration

Today's Date:______________

Client Name:____
Last *First* *Middle*

DOB:_____/_____/_________ **Social Security # :**__________________________________
MM *DD* *CC YY*

Sex: M F
(please circle)

Marital Status: S M W D
(please circle)

Address:____

_______________________________________ ____________________ __________________
City *State* *Zip*

Home Phone:__________________________ **Work Phone:**____________________________

Email Address:____

Occupation:_____________________________ **Employer:**____________________________

Employer's Address:____

_______________________________________ ____________________ __________________
City *State* *Zip*

Spouse Name:____
Last *First* *Middle*

DOB:_____/_____/_________ **Social Security # :**__________________________________
MM *DD* *CC YY*

Sex: M F
(please circle)

Work Phone:____________________________

Occupation:_____________________________ **Employer:**____________________________

Employer's Address:____

_______________________________________ ____________________ __________________
City *State* *Zip*

Referring Physician: ____________________________________**Phone:**__________________

Primary Physician:_____________________________________

………………………………..

CONTACT INFORMATION

Nearest relative not living with you:____

Address:____

_____________________________________ ___________________ _________________
City *State* *Zip*

Home Phone:__________________________ **Relationship to Client:**___________________

Emergency Contact: ____

Home Phone:__________________________ **Relationship to Client:**___________________

Signature:____ **Date:**______________________

Name: ____**Date:**______________________

Name of person signing if different from patient. If patient is minor, responsible parent or guardian must sign instead of patient.

Updated: 06/08/10 TA/JMB