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Name of Client: **Date: / /**

Date of Birth: / / Age Sex: M F

Address: **Postal: -**
Home Phone: **Fax:** **Other Phone/Pager**

Education completed:

Occupation Employer Work phone

Marital status _____ # of years _____

Spouse's name _____ DOB:_____ Age_____

Occupation Employer Work phone

Special billing arrangements
Contact person

Special telephone procedures: (Leave message etc.)

Children (if applicable) **Birth Town** **School** **Grade**

_____
_____
_____
_____
_____
_____

GP Name **Address** **Phone**

Current health problems:

Current medications:

Current Allergies:

Who referred you here?

Emergency contact person **Relationship** **Phone**

*ANY INFORMATION PROVIDED BY YOU IS CONFIDENTIAL AND **WILL** NOT BE **DISCLOSED** TO ANY PERSON WITHOUT YOUR EXPRESSED CONSENT*

I am personally responsible for payment of this account which Includes appointments cancelled within 24 hours of appointment time and for subsequent collection costs if necessary. I understand that the current fee for service is $225.00 per clinical hour.

Signed:_____ Date:

If it is necessary to send a bill, a $5.00 charge will be added to your account