cureative

New Client Orientation Sheet

PATIENT INFORMATION:

Name:_____ Today's Date:_____
Age:_____ Date of Birth:_____
Email address: _____ Phone #:_____
Address:_____
Can a confidential message be left at this number? YES | NO
Occupation and hours:_____

PAYMENT INFORMATION:

Person Responsible for payment (if not client):_____
Relationship to patient:_____
Payment type: _____ Payment amount: _____
Email address: _____ Cell Phone #:_____
Can a confidential message be left at these numbers? YES | NO

MEDICAL INFORMATION:

Referred by/how did you hear of our services:_____
Primary care provider:_____Contact number:_____
Therapist/Psychologist:_____Contact number:_____
Other:_____

Food Allergies/current medications:

_____
_____
_____
_____

Food/Dietary/ Supplements (incl. vitamin-minerals)

_____
_____
_____
_____

Exercise: (Please describe any sports involvement, exercise/activity routines, etc. including frequency and duration)_____
_____
_____
_____
_____