Date: Name: ________________________________

Date of Birth: ____________________ Anniversary (if in relationship):

____

Address: ____

City: _________________, _____ Postal Code: _________________________

Phone Number: OK to call OK to leave message
(Home) ___________________________ Yes No Yes No

(Cell) ____________________________ Yes No Yes No

Email: ______________________________ OK to contact/correspond via email? Yes No

Would you like to be signed up for my newsletter?

☐ Relationship Newsletter ☐ Eating Disorder Newsletter

Referred by: _____________________ Ok to acknowledge Referral? Yes No

Family Doctor: ____________________________ OK to Contact Doctor ☐ Yes ☐ No

Medications: ____

In case of emergency, please notify:___________________________________

Phone Number of Emergency Contact:

Credit Card Number & Signature (for sessions cancelled without 48 hrs notice)

____ Expiry: ___________________

Name on Card: _____________________________________ Card Type: Visa MC

Additional Information:

Signature: ____