BALANCE & BLOOM

SPECIALIST WELLNESS COUNSELLOR

Registration No: SWC24/8068 (ASCHP)

Client Intake Form

Full Name:

Date of Birth: Gender:

Address:

City: State/Province:

Zip/Postal Code: Country:

Phone Number: Email Address:

Age: ID Number:

Religion: Ethnicity:

Employment: Cell Number

GP Name & TeL

Any other Drs (if applicable)

NAME OF PARENT/LEGAL GUARDIAN (IF CLIENT IS UNDER 18 YEARS OF AGE)

Parent/Legal Guardian 1

Full Name:

ID Number:

Email Address: Cell Number

Signature

Parent/Legal Guardian 2

Full Name:

ID Number:

Email Address: Cell Number

Signature

Both parents consent is needed.

Acknowledgement

I undersigned, understand and acknowledge; that the person I am about see is a Specialist Wellness Counsellor registered with the ASCHP.

Client Signature

_____

Full Name -

Date -