The WellBeing Academy

Healthy-Lifestyle Change/Wellness Training, Mentoring & Coaching

P.O. Box 70494 Houston, TX 77270 PH: 832.409.3242 yourwellbeingmatters@gmail.com

(Fax completed form to 713.422.2428 & notify office at least 48 hrs prior to scheduling)

Client Information Sheet

Referred By: _____ Today's Date: _____

Referred for or seeking service for presenting issue of: _____

Client Name: _____ Gender: _____

Date of Birth: _____ Driver's License #& State Issued: _____

Permanent Address: _____ E-mail* _____

City: _____ State: _____ Zip: _____ May we exchange emails with you @ above address? Yes/No

Cell/Home Phone: _____ Work/Alternate Phone: _____
May we leave a message @ above PH#? Yes / No May we leave a message @ above PH#? Yes / No

Marital Status: (Circle one) single / engaged / co-habitating / partnered / married / separated / divorced / widowed / other
(explain) _____

Occupation: _____ Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION (If someone other than client is paying for services or is legal guardian):

Name: _____ Gender: _____
Relationship to Client: _____ Date of Birth: _____
Address: _____ E-mail* _____
City: _____ State: _____ Zip: _____ May we exchange emails to named @ above address? Yes/No
Cell/Home Phone: _____ Work/Alternate phone: _____
May we leave a message @ above PH#? Yes / No May we leave a message @ above PH#? Yes / No

Occupation: _____ Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____

Personal Phone#: _____ Email Address: _____
May we leave a message @ above PH#? Yes / No May we exchange emails to named @ above address? Yes/No
Work Phone#: _____ Mobile#: _____
May we leave a message @ above PH#? Yes / No May we leave a vm/text message @ above PH#? Yes / No

Payment of Services: My signature below indicates I agree to pay for services myself or have responsible party named above pay for services on my behalf and indicates I allow authorization of release to my responsible party or emergency contact for the coordination and follow-through of my services. I understand payment of services is made prior to the delivery of services. I understand that rescheduling must be done greater than 48 business hrs prior to my scheduled appointment. (Initial :_____)
My signature below indicates I authorize the release of any personal, medical or other information necessary for processing and payment of services due to The WellBeing Academy, LLC for the client named above.

Client Signature: _____ Date: _____
Or Legal Guardian's Signature: _____ Date: _____