9 CORNERS
CENTER for BALANCED LIVING

Client Information

Welcome to 9 CORNERS! We would like to know more about you. Please fill out the following information for us to better serve you. This information will be kept confidential within the 9 CORNERS practitioners and staff. Thank you!

TODAY'S DATE: _____ CLIENT NAME:_____

ADDRESS:_____ CITY:_____ ZIP: __ __ __ __ __

HOME PHONE: (__ __ __) __ __ __- __ __ __ __ WORK PHONE: (__ __ __) __ __ __- __ __ __ __

CELL PHONE: (__ __ __) __ __ __-__ __ __ __ E-MAIL ADDRESS: _____

DATE OF BIRTH: __ __/__ __/__ __ __ __ MARITAL STATUS: ☐ 01 single ☐ 02 married ☐ 03 divorced ☐ 04 widowed

SEX: ☐ 01 male ☐ 02 female OCCUPATION: _____

DO YOU HAVE CHILDREN?: ☐ 01 yes ☐ 02 no IF YES, HOW MANY: ☐ 01 one ☐ 02 two ☐ 03 three ☐ 04 four+

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

HOW DID YOU LEARN ABOUT 9 CORNERS? (CHECK ALL THAT APPLY)

☐ 01 ad ☐ 02 drove by ☐ 03 friend ☐ 04 health club ☐ 05 insurance plan

☐ 06 radio ☐ 07 mailer ☐ 08 website ☐ 09 workshop ☐ 10 speaking event

☐ 11 TV ☐ 12 yellow pages ☐ 98 other_____

What are the goals you would like to accomplish with your time at 9 CORNERS? Please list:

_____

WOULD YOU LIKE TO BE ADDED TO OUR MAILING LIST? ☐ 01 yes ☐ 02 no

PLEASE CHECK THE THERAPIES AND PROGRAMS YOU MIGHT BE INTERESTED IN:

THERAPIES:

☐ 45 Active Isolated Stretching
☐ 01 Acupressure
☐ 02 Acupuncture
☐ 36 Allergy Relief
☐ 40 Anger Management
☐ 03 Biofeedback
☐ 04 Bodywork/Massage
☐ 05 Chiropractic Care
☐ 06 Craniosacral Therapy
☐ 07 Depression/Anxiety
☐ 08 Exercise Programs
☐ 09 Feldenkrais
☐ 11 Guided Imagery
☐ 12 Health Appraisal
☐ 13 Homeopathy
☐ 37 Hypnosis
☐ 14 Life Coaching
☐ 43 Lifestyle Change
☐ 15 Lymphatic Drainage
☐ 10 Loss/Grief Support
☐ 16 Meditation
☐ 34 Naturopathy
☐ 17 Neuromuscular Techniques
☐ 18 Nutrition
☐ 19 Performance Enhancement
☐ 21 Physical Rehabilitation
☐ 44 Reichian Therapy
☐ 22 Reiki
☐ 39 Relationship Coaching
☐ 23 Stress Reduction
☐ 24 Supplements & Vitamins
☐ 25 Transition Coaching
☐ 26 Weight Management
☐ 27 Woman's Health

PROGRAMS:

☐ 28 Cleansing/Detoxification
☐ 41 Core Strengthening (abs & back)
☐ 35 Feng Shui
☐ 29 Headache Management
☐ 31 Pain Relief
☐ 32 Posture Re-structuring
☐ 33 Smoking Cessation
☐ 30 Stress Reduction
☐ 38 Sleep Coaching

please turn over ☞

Financial Policy

I understand and agree that the health and accidental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipts. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. ***I further understand that I need to give 24 hours, or one business day, notice prior to canceling my appointment.***

Client's
Signature_____Date_____