Balance and Thrive, LLC
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Initial Information Form

Date_____________________________________

Client Name: _______________________________ DOB: ______________

Parent's Name: _____________________________
(If client under 18)

Address____

All numbers I can reach you on: ____

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Are there any phone numbers I cannot leave a message on? _______________________________

Are there phone numbers I can leave a message on? _____________________________________

E Mail: ____

List any medical conditions: ____

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List any medicines: ____

Name of doctor who prescribes medication: ____

Who referred you: ____

May we contact person who referred you? ____

I would like to be included on the mailing list to receive Service Updates and Wellness Journals through mail and Constant Contact: Yes______ No_______. I authorize Balance & Thrive to use my home address and email address listed above to send this information. _________________ (signature of client or parent).

Any other information you would like to provide:

X____ Signature _______________ Date