

# Faithful & True Ministries, Inc.

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## Client Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E-Mail: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ May we leave a message?  Yes  No

Work: \_\_\_\_\_ May we leave a message?  Yes  No

Cell: \_\_\_\_\_ May we leave a message?  Yes  No

(Please put a "check" behind the number you prefer to be called in case your appointment needs to be rescheduled.)

List any reasons for your visit today:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How were you referred?

\_\_\_\_\_

List any health care professionals that you have consulted about your problem and how long you have worked with them.

\_\_\_\_\_  
\_\_\_\_\_

Are you on any medications? If yes, what are they?

\_\_\_\_\_  
\_\_\_\_\_

Who should we notify in case of an emergency?

\_\_\_\_\_  
\_\_\_\_\_