Cheryl Craig, RD

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Registration Form

Please fill out this registration form and bring it to your first session.

Client Name: _____Date of Initial Session:_____

Address/City/Zip: _____

Home Phone: _____ Cell Phone:_____

Work Phone:_____ Email: _____

Date of Birth:_____ Age:_____Birth Place:_____

Social Security Number: _____-_____-_____

Marital Status: _____Alias(es): _____

Driver's License Number/State: _____

Employment Status: Full-time:_____ Part-time:_____ Student:_____ Not Working:_____

Employer:_____ Position:_____

Address/City/Zip: _____

Responsible Party: Self:___ Spouse:___ Parent/Legal Guardian:___ Other:_____

Responsible Party Name:_____

Address/City/Zip:_____

Home Phone: _____ Cell Phone:_____

Work Phone:_____

Employment Status: Full-time:_____ Part-time:_____ Student:_____ Not Working:_____

Employer:_____ Position:_____

Address/City/Zip: _____

For Minors:

Parent/Legal Guardian Name:_____

Address/City/Zip: _____

Home Phone: _____ Cell Phone:_____

Work Phone:_____

Employment Status: Full-time:_____ Part-time:_____ Student:_____ Not Working:_____

Employer:_____ Position:_____

Address/City/Zip: _____

Emergency Contact: (nearest relative not living with you)

Name: _____Relationship:_____

Address/City/Zip:_____

Home Phone: _____ Cell Phone:_____

Work Phone:_____

Health Insurance:

Company:_____ Insured:_____

Insured's ID#:_____ Group #:_____ Plan #:_____

Phone #:_____

Referral source: _____

What is the primary issue that leads you to seek nutrition counseling?

_____

_____

What are your goals for nutrition counseling?

_____

_____

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____Date:_____