Morrison Therapy & Training

Client Information Sheet: Please fill out and sign

Personal Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____City: _____State: _____ Zip: _____

Cell phone: _____ Other: _____

Email address: _____

Employer/School: _____ Occupation/Studying: _____

Relationship Status: _____ # of children and ages: _____

Emergency Contact (name and number): _____

Primary Care Physician: _____

Current medications and amounts: _____

_____

Are you seeing any other health care professional such as a Naturopathic Physician, Acupuncturist or Massage Therapist? Please list: _____

_____

Are you or anyone else concerned about your current use of medication, alcohol or drugs? Yes No

Please describe symptoms that interfere with your wellness:

_____

_____

What brings you Joy?

_____

_____

Please describe what you would like to experience differently through therapy:

_____

_____

Is there anything else you would like me to know about you?

_____

_____

_____ _____

Client Date

_____ _____

Print Name Date of Birth (if under 13)

Payment: I do not bill insurance. If you would like a form that you can submit to your insurance I will provide one (referred to as a Super Bill). You may pay by check or through my PayPal account:
Payment: https://morrisontherapy.com/contact/fees-and-payments/