ALIST WELLNESS CENTER LLC

25 EAST WILLOW ST.
MILLBURN, NEW JERSEY 07041

CLIENT REGISTRATION INFORMATION

In order to serve you properly, we will need the following information. **(Please print)**

Last name: _____First name: _____Initual:_____

Address: _____City: _____ State: _____ Zip_____

Date of Birth: _____Age: _____ M /F_____ Marital Status_____

Home phone: _____Cell phone: _____Email:_____

Employer_____ Your occupation: _____Work phone: _____

EMERGENCY CONTACT INFORMATION:

Name of person: _____Relationship _____

Address: _____City:_____Zip:_____

Home phone: _____ Work: _____ Cell: _____

CLIENT REFERRAL INFORMATION:

Referred by: _____ If referred by a friend, may we thank her or him? YES___NO____

Phone Book _____Referral _____Website_____ TV ____NJ Naturally____Other_____

Doctor's Name: _____phone:_____

Please follow the instructions of the Therapist. You must be draped/covered at all times.

Signature: _____ Date: _____