

Harrisonburg Center for Healing  
1737 Erickson Avenue  
Harrisonburg, Virginia, 22801  
Phone: (540) 830-5443  
Fax: (540) 214-2657

Registration Information:

Client's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

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

Home Phone#: \_\_\_\_\_ Student: \_\_\_\_\_ Yes \_\_\_\_\_ No

Cell Phone#: \_\_\_\_\_ Employed: \_\_\_\_\_ Yes \_\_\_\_\_ No

It is acceptable to send me a text message \_\_\_\_\_ Yes \_\_\_\_\_ No

Client's Employer \_\_\_\_\_

Address \_\_\_\_\_

If the client is a minor, please answer the following:

Legal Guardian's Name(s) and Relationship:

\_\_\_\_\_

Legal Guardian's Contact #: \_\_\_\_\_

For all clients, please provide the information requested below:

Emergency Contact Name and Phone #:

\_\_\_\_\_

Is the client covered by health insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Referral Source: \_\_\_\_\_