



Client Name: _____ Home Phone: _____

Home Address: _____ City: _____ State: _____

Zip: _____ E-mail address: _____ Cell Phone: _____

Date of Birth: ____/____/____, Age _____ Relationship to you: _____

In Case of Emergency Notify: _____

Phone: _____ Address: _____

Who referred you/how did you hear about us? _____ Phone: _____

1. ***I understand that Somatic Science® includes educational training methods and processes that are supported in their use by scientific evidence, however their effectiveness for me in achieving my goals cannot be guaranteed in advance.***
2. ***I understand that no guarantees concerning the above training methods or their efficacy has been given to me, and that I volunteer to receive this training solely because of my own personally held belief that the aforementioned training approach may be effective in my particular care.***

I hereby certify that I have read and fully understand the entire contents of this form, and sign it freely and voluntarily without inducement.

Signature: _____ Date: _____ Parent's/guardian's signature if under 18:

Signature: _____ Date: _____

Parent's/guardian's name & signature if client is under 18 years of age: _____



Please help us protect your privacy by checking the appropriate boxes.

- | | | |
|-----------------------------|---------------------------------|--|
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my HOME answering machine. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with any other person. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my WORK voice mail. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with co-workers. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my CELL PHONE voice mail. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with any other person answering cell phone. |