SPORTS THERAPY ASSOCIATES
MERIDITH LLEWELIN
760-727-7406

# NEW CLIENT INFORMATION

NAME ____________________________________________________________

DATE _____________________________________________________________

ADDRESS _________________________________________________________

CITY___________________________ STATE________ ZIP_________________

PHONE_______________ WORK_______________CELL___________________

E-MAIL ___________________________________________________________

BIRTHDAY_______________________ SEX __________ AGE ______________

REFERRED BY_______________________________________________________

DATE INJURED______________ BRIEFLY EXPLAIN HOW INJURY OCCURRED:

______________________________________________________________________

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Payment is expected at time of visit. Please notify us 24 hours in advance if you need to change or cancel your appointment. You will be charged for missed appointments. The first missed appointment will be charged at ½ your appointment fee, and all other missed appointments will be charged the full amount. We do make every effort to fill appointments when you have to cancel, but if we are unable to fill your space, you will be charged when you fail to cancel your appointment. Thank you for your understanding.

Client's signature _____________________________________________________

Parent or Guardian signature ____________________________________________