CLIENT REGISTRATION FORM

Please complete the entire form.

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____ Male: ☐ Female: ☐

NICKNAME:_____

DATE OF BIRTH: _____ AGE: _____

SSN:_____ RACE: _____

Special Needs: (check all that apply.)

- ☐ **Wheelchair**
- ☐ **Blind**
- ☐ **Cane**
- ☐ **Hearing Impaired**
- ☐ **Walker**
- ☐ **Needs extra assistance**
- ☐ **Other: _____**

ADDRESS: _____

CITY: _____ STATE: ____ ZIP CODE: _____

PHONE NUMBER: _____

EMERGENCY CONTACT: _____ PHONE: _____

The information in this document is complete and accurate to the best of my knowledge.

Client Signature: _____ Date: _____

Print Name: _____

CGCTA Use Only:

Approved By: _____ Date:_____