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: (please circle)

☐ **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: _____