



CareBridge Health

Your bridge to better health

REGISTRATION INFORMATION

Full Legal Name: _____

Preferred Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Preferred Method of Contact (phone/text/email): _____

Emergency Contact Name & Phone: _____

Preferred Pharmacy: _____

ABOUT YOUR VISIT

1. Why are you coming in now?

2. In an ideal world, what about your health would you change?

3. If this visit is due to a current health issue, how bad has the problem become?

MOTIVATION & COMMITMENT

How motivated are you to change?	0 1 2 3 4 5 6 7 8 9 10
How much time per week can you dedicate to your health?	_____ hours per week
How urgent does this feel to you?	Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/>

ACKNOWLEDGMENTS

- I consent to be contacted by phone, text, or email for appointment and care coordination.
- I acknowledge that CareBridge Health is a direct-pay practice unless otherwise arranged.
- I understand I may receive separate consents for treatment and privacy practices.

Signature: _____

Date: _____