



BRIDGEPOINT CENTER FOR EATING DISORDERS

PART A - Basic Information (Filled out by applicant)

Program applying for:				
Dates:				
Client name:				
Date of Birth:				
SHSP Number:				
Current Address:				
	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">Box/Street</td> <td style="width: 33%; border: none;">City, Province</td> <td style="width: 33%; border: none;">Postal Code</td> </tr> </table>	Box/Street	City, Province	Postal Code
Box/Street	City, Province	Postal Code		
Phone Numbers: Home	Work:			
Cell:				
Client email address:				
Next of Kin: Name:				
Relationship:	<small>Next of kin will be contacted in emergency situation</small>			
Address:				
	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">Box/Street</td> <td style="width: 33%; border: none;">City, Province</td> <td style="width: 33%; border: none;">Postal Code</td> </tr> </table>	Box/Street	City, Province	Postal Code
Box/Street	City, Province	Postal Code		
Phone Numbers: Home:	Work:			
Cell:				
Counsellor's name:				
Phone:	Email:			
Physician's name:				
Phone:	Email:			
Date:				
Signature:				

BridgePoint is a Scent Free Facility

PART A - Getting to know you

1. a) What are your supports?

b) If you are working with a counsellor what issues are you currently working on?

2. Do you have any health issues or concerns?

3. Do you have any allergies?

4. Describe your current experience with food.

5. What other information would you like us to know about you?

Printed Name:	
Signature	
Current Phone Number:	Date: