Heal It Forward Network Assistance Application

Instructions: Please complete this form entirely.

Upon completion please return by fax, email, or mail to: The Dr. John E. Upledger Foundation

11211 Prosperity Farms Road, D-223, Palm Beach Gardens, FL 33410

Phone: 561.622.4588 **Fax**: 561.627.9231 **Email**: info@upledger.org

Today's Date: _____

First Name: _____ Last Name: _____ DOB: _____/____/_____

(*If client is less than 18 years of age):*
Parent/Guardian First Name: _____ Last Name: _____

Address _____Apt #_____

City: _____State: _____ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____

How did you hear about the Heal It Forward Network? _____

_____

Do you currently receive CranioSacral Therapy? Y / N

If so, who is your ongoing therapist? _____

What are your top three treatment needs?

1. _____

2. _____

3._____

Do you have health insurance? Y / N If yes, please list your current provider: _____

_____

Do you have Medicaid (Title 19)? Y / N

Dr. John E. Upledger Foundation

To be completed by the clients prescribing healthcare provider.

Healthcare Provider Name _____License #: _____

Client Diagnosis _____Date of Diagnosis _____

Is Patient in Active Treatment and/or Ongoing Follow-Up? Yes No

Hospital/Clinic_____

Address _____

City: _____State: _____ZIP: _____Phone: _____

_____ _____

Healthcare Provider Signature **Date**

_____ _____

Client or Parent/Guardian Signature **Date**

For JEUF Office Use Only:

Date Received: _____Received by: _____

Comments: _____

_____