



Noble Steps Healing: *The Calmer Mom Project*

Michelle Noble, LMT, BF, CFMW

5005-200th St SW

Lynnwood, WA 98036

(206) 938-7627

Michelle@CalmerMom.Solutions

www.CalmerMom.Solutions

Client Information: Please Complete & Print Clearly. All Information is Confidential.

Date: _____

Name (First/Last): _____ Preferred Name (i.e. Sue for Susan) _____

Preferred Pronouns (i.e. she/he/ze/they/etc): _____ Birthdate: _____ Age: _____

Address: _____ Phone #: _____ Texting Okay? _____

City/State: _____ Zip Code: _____

Email Address: _____

May I Add You to My Newsletter/Practice Updates List? ☐ Yes ☐ No

Note: Newsletter List is confidential & I will never share it without your consent. However, the list manager is secure, but not HIPAA compliant. You may unsubscribe at any time.

Emergency Contact Name/Phone: _____

How did you find out about me?

☐ Advertising? Where: _____

☐ Another Health Care Provider. Name: _____

☐ From friends/family? May I contact them to thank them and offer a \$25 discount on services?

☐ No thank you. ☐ Yes. Name: _____ Phone: _____

Household Information:

Who lives with you, including pets: _____

If you have children, what are their first names and ages? _____

Other Information:

For Female Bodies:

Number of Past Pregnancies: _____

Number & Types of Births: _____

☐ Currently Pregnant?

Due: _____ Weeks Along: _____

For Babies:

☐ Nursing/Feeding Issues ☐ Sleep Issues

☐ Tongue Tie ☐ Colic

☐ Difficult Delivery

For All Bodies:

Is there anything else about you or your body you'd like me to know? _____

If you could get anything out of your session, what would it be? _____

😊 **Please
Continue
& Sign On
Page 2....**

Client Signature Page:

Please check the boxes to acknowledge the following and sign. If you have questions or concerns, please let me know so we can make sure we've set up clear communication from the beginning. Thank you!

☐ I have read, understand, and agree to *Noble Steps Healing: The Calmer Mom Project Office Policies*, including payment and cancellation, the privacy and protection of my information, and the scope of care Michelle can provide.

☐ If I have questions, concerns, or am not comfortable with any aspect of care or service from Michelle I will take responsibility for talking with Michelle about what is coming up for me.

Client Signature: _____ Date: _____

Printed Name of Parent/Guardian (If applicable): _____

Signature of Parent/Guardian: _____

Thank you!

Michelle