

# BRAIN INTEGRATION TECHNIQUE CLIENT INFORMATION

CLIENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ ZIP CODE \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE/YEAR \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ STUDENT'S AGE \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK/CELL: \_\_\_\_\_

PARENTS' FIRST NAMES (if minor) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Referred by: \_\_\_\_\_

Brief description of learning difficulties or life frustrations that brought you to Brain Integration:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Relevant history of difficulties/frustrations referenced above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I declare that the above information is correct to the best of my knowledge.

I also understand that all payments are due on date of rendered service.

A \$15 late fee will be assessed if I am over 15 minutes late for a scheduled appointment, and is due upon my arrival.

A \$35 fee will be assessed if I do not give a 24 hour notice of my need to cancel an appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_