

BRAIN INTEGRATION TECHNIQUE CLIENT INFORMATION

CLIENT'S NAME: _____

ADDRESS: _____

_____ ZIP CODE: _____

SCHOOL: _____ GRADE / YEAR _____

DATE OF BIRTH: _____

STUDENT'S AGE: _____ PARENTS' FIRST NAMES: _____

HOME PHONE: _____ BUSINESS PHONE: _____

EMAIL ADDRESS: _____

REFERRED BY: _____

Brief description of learning and other problems that brought you to Brain Integration Therapy:

Relevant history of above complaint or problem:

