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:

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Relevant history of above complaint or problem:

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