NEUROFEEDBACK FOR HEALTH

NEW CLIENT INFORMATION

Name_____ Date of Birth_____

Address_____

City/State/Zip_____

Phone (home)_____ (work)_____ (cell)_____

E-mail_____ Occupation_____

EMERGENCY CONTACT

Name_____ Phone_____

Relationship to Client_____

PARENT OR GUARDIAN OF MINOR

Name_____

Address_____

City/State/Zip_____

Phone (home)_____ (work)_____ (cell)_____

E-mail_____ Occupation_____

PRIMARY SYMPTOMS OR DIAGNOSIS

_____

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_____

HAVE YOU EVER HAD NEUROFEEDBACK BEFORE? IF SO, WHEN?

_____

NAME OF TREATMENT PROGRAM/SOBER LIVING, CONTACT NAME/NUMBER

_____

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REFERRED BY - NAME/NUMBER

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