Crossinology®

BRAIN INTEGRATION TECHNIQUE CLIENT INFORMATION

CLIENT'S NAME:____

ADDRESS:____

____ZIP CODE__________

DATE OF BIRTH_________________ AGE:__________

EMPLOYER:____

TYPE OF WORK: ____

HOME PHONE:_________________BUSINESS PHONE:__________________

EMAIL ADDRESS:____

Referred by:____

Brief description of problem(s) that brought you here:

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Relevant history of above complaint or problem:

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I declare that the above information is correct to the best of my knowledge.
I also understand that payment is due on date of rendered service.
Cancellations require 48 hours notice or full fee for appointment will be charged.

Signed:_____________________________________ Date:_______________