



## Neurofeedback & Counseling Services

### General Information

Date: \_\_\_\_\_ How did you hear of us? \_\_\_\_\_

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Other: \_\_\_\_\_ E-Mail: \_\_\_\_\_@\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_