PNT – Pain Neutralization Technique

Name ______________________________Called Name________________________Date_____________

Home Address______________________________City____________________State____Zip__________

Home Phone____________________Work Phone________________Cell Phone____________________

Date of Birth_________________________Age_________Gender M / F

Please describe briefly main area of pain:

Where:____

How long:____

Any specific cause:____

What have you tried:____

Please note:

- Thursday afternoon appointments are absolutely free of charge
- If you can and want to, we encourage you to leave a cash or check donation for a local food bank

Client Signature____Date_________________

Guardian's Signature Authorizing Care______________________________________Date___________

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name _________________________________Phone _________________Work Phone_______________

Any other comments: