



(YSNT-HRF)

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TESTIMONIAL FORM

1. Patients Name (In Capital) _____
(In case of minor Guardian Name) _____
2. Full Address : _____
3. Date of Birth : _____ Age: _____ M/F: _____ Blood Group: _____
4. Telephone / Fax / Mobile : _____ Email : _____
5. Patient's Ailment : a) Description in Detail (an extra sheet may be attached if necessary)

b) Duration of suffering : _____
7. Previous Medical Treatment : _____
a) Allopathic / Ayurvedic / Homeopathic / Any other : _____
b) Name's of doctors attended : _____
8. Duration of Neurotherapy treatment taken by the patient : _____
9. Relief in ailment experienced by the patient (answer in detail) _____

10. Further comments (if any) :- _____

11. Patient's / guardian Signature : _____
12. Attachments : a) medical reports
b) Neurotherapy treatment records
c) Others
d) Total pages attached : _____
13. Neurotherapist's Signature :-(Full Name / Address / Date) : _____

14. Research co-ordinator's Remarks :- (Full Name / Address Date) _____

