LAJPATRAI MEHRA NEUROTHERAPY RESEARCH & TRAINING INSTITUTE

(LMNT RTI)

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TESTIMONIAL FORM

1. Patients Name (In Capital) _____
   (In case of minor – Guardian Name)
2. Full Addres : _____
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 treayment 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) _____

    _____

    _____

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