NAET Patient Information

Date:_____

Name:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Birth:___/__/____ Age:_____ Sex: M / F Height:_____ Weight:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

Employer:_____ Occupation:_____

Employer's Address: _____

Driver's License #:_____ State:_____ Exp. Date __/__/____

Social Security #:_____ Marital Status: M/S/D/W # of Children: B__ G__

Name of Spouse: _____ Occupation:_____

Contact in Emergency: _____ Phone: _____

Medical Insurance: Y__ N__ Insurance Co. Name:_____

I.D.#_____ Name of Insured:_____

Consent to Treatment

I _____ hereby consent, authorize and request _____ to administer the treatment deemed advisable and necessary to my (my ward's) condition in accordance with his/her expertise. I agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from such treatment.

Print Name:_____

Patient's Signature:_____ Date:_____

Witness Name:_____

Witness Signature:_____ Date:_____

Family History

Parents Living: Father (age)_____ Mother (age)____ Brothers_____ Sisters_____

Is there any fam. history of: Allergies:___ Diabetes:___ Hypoglycemia:___ Asthma:___

Cancer:___ Mental Disease:___ Lung Disease:___ Heart Disease:___ Skin Problem:___

Hypertension:___ Arthritis:___ Any other health problems?_____

Did your mother have: Gestational diabetes?___ Heavy metal toxicity?___ Mercury toxicity?___

Severe yeast infection?___ Do you have a relative with similar problems?___

Relationship_____ Was the mother on any drugs during the pregnancy?_____

List the Drugs:_____

Did the mother use tobacco during pregnancy?___ Smoked cigarettes?___ Did the Child have a head injury during infancy?___ Before the age of three?_____ Fall____ Accidents____

Sudden fright for any reason? _____

Explain the above incident(s) if any in detail: _____

_____

Personal History

Childhood diseases: Measles: ___ Mumps:___ Chicken Pox:___

Unusual childhood diseases: _____

Immunizations: List and give names: _____

_____. Any severe reactions? _____.

Any severe reactions to other drugs? ___ Describe:_____

_____.

Are you taking any medications now? _____ List all names:_____

_____.

Any surgery? _____ Do you have ear tubes, or any other devices or aids (like shunts, hearing aids, pacemaker, etc.)?_____.

Do you take any vitamins? ___ List:_____.

Do you exercise? Y or N Regularly___ Infrequently____ Seldom___

Hobbies: _____.

List any known allergies: _____

_____

_____

_____.

Past History

List any previous significant injuries (slips, falls, auto accidents, etc.) and give the dates:

_____

_____

_____.

List any past significant illness and give the dates: _____

_____.

List all operations and give the dates: _____

_____.

Have you ever been to a chiropractor before? Y / N ? Date of last adjustment__/__/____

Name and address of your chiropractor: _____

_____.

Have you ever seen an acupuncturist? Y /N ? Date of last treatment __/__/____

When were you last seen by a physician? _____

For what purpose? _____.

Your current doctor's name and address: _____

_____.

Doctor's Phone #: _____

Date of Last Physical Exam: __/__/____

List all foods and beverages consumed more than three times a week:

_____

_____

_____.

If you suffer from exhaustion or fatigue, describe how you feel and what time of day or night you experience these symptoms, including whether they occur daily or occasionally.

_____

_____

_____

_____.

Do you suffer from any of these symptoms? (B= Before treatment, A= After NAET treatment)

___	___ Arthritis	___	___ Excessive Gas
___	___ Headaches	___	___ Insomnia
___	___ Hot Flashes	___	___ PMS
___	___ Blurred Vision	___	___ Poor Memory
___	___ Dizziness	___	___ Sexual Impotency
___	___ Morning Fatigue	___	___ Excessive Perspiration
___	___ General Fatigue	___	___ Palpitation of the Chest
___	___ Labored Breathing	___	___ Dry Skin
___	___ Shortness of Breath	___	___ Poor Appetite
___	___ Indigestion	___	___ Excessive appetite

___ ___ Heart Burn

___ ___ Lump in the Throat
___ ___ Throat Constriction
___ ___ Numbness
___ ___ Fainting Spell
___ ___ Light Headedness
___ ___ Swelling of the Joints
___ ___ Loose Stools
___ ___ Candida
___ ___ Pain Disorders

___ ___ Night Sweats

___ ___ Nerves
___ ___ Depression
___ ___ Learning Disabilities
___ ___ Asthma
___ ___ Chemical Sensitivities
___ ___ Constipation
___ ___ ADHD
___ ___ Autism
___ ___ Other

To Be Filled Out By Doctor/Physical Examination

Pulse: _____ Resp: _____ Blood Pressure: Sitting_____

General Appearance: _____

_____

_____.

X-Rays: What Part? _____ Date: __/__/____ Findings:_____

_____.

Lab Work?: _____.

Computer Evaluation?: Date: __/__/____ NST Evaluation Date: __/__/____

Findings: _____.

Diagnosis: _____.

Treatment Plan: _____.

Date of Discharge: __/__/____ Final diagnosis at Discharge: _____.

Name of Doctor: _____ Signature at Discharge:_____.

Patient's Signature: _____ Date: _____

Parent/ Guardian's Signature: _____ Date: _____