Patient Intake
Allergy Elimination

Date______________ 20 ____

Name ____
Date Of Birth ____________________________M__F___
Home Address ____
City ________________________ State ______ Zip _______
Home phone _______________ Cell phone_________________________
E-mail____
Married __ Single__ Social Security # ___________________
Occupation ____
Employer__________________________City____________State______
Zip_____ Work phone_______________
What is the best way to contact you? ____________________________
Who can we thank for referring you?_____________________________

The technique named NAET, (Nambudripad Allergy Elimination Technique) was discovered by Dr. Nambudripad approximately 30 years ago. At this office, we are by no means guaranteeing that all patients will have all their allergies eliminated.

Over the years that I have been practicing NAET, I have observed many patients that, when following all the recommendations and avoidance principles that we advise, report improvements in many of their food intolerance's and allergies. They also report that some of their allergic responses to other substances have also improved. Many patients also report they "feel" calmer and emotionally balanced.

Naet does not treat disease, but rather assist in improving health and well-being.

When patients come to my office and seek care for the above concerns, I do not guarantee that any or all of these results will be achieved. This is explained at the initial consultation.

I do, however, explain that when the avoidance principles and recommendations are adhered to, the results are usually better.

Please sign at the bottom of this page, agreeing that you understand that by beginning this program, the results can't be guaranteed.

If you have any questions, now or at any time during your care at this office, please feel free to contact me or my staff.

Patient Name____________________________If minor, Parent/Guardian ______________________

Patient Signature_________________________Parent/Guardian Signature______________________

Name:____**Date:**___________

Major complaint (reason for visit)____
____
Have you ever had this condition or similar condition before? **O** Yes **O** No
Have you ever received treatment for this condition? If yes, when? By whom?
____
____
What was the diagnosis? What were the results of the treatment?
____
____
Has the condition gotten: **O** Better **O** Worse **O** Same
What makes it better?____
____
What makes it worse?____
____
Describe what caused it and how it started.__________________________________
____
____

Family Medical History:
O Cancer **O** Diabetes **O** High or low Blood pressure **O** Heart Trouble **O** TB **O** Asthma
O Allergies **O** Kidney disease **O** Epilepsy **O** Liver Disease **O** Ulcers **O** Sinus Problems
O Eye Disease **O** Arthritis **O** Alcoholism **O** Spinal Problems **O** Mental Disorder
O Drug Addiction Other:____

Personal Medical History:
(Include dates) Major Surgeries – Illness (from list above) – Diseases – Accidents: ___________
____
____
____

Medications recently taken: ____
____

Known Allergies: (drugs, chemicals, foods, animals, seasonal, etc…)
____
____
____
____
____
____
____

Contagious Diseases History:
O HIV **O** AIDS **O** Hepatitis **O** Venereal Disease **O** Herpes Other_______________________

Habits:
O Cigarettes **O** Soft Drinks **O** Salt **O** Coffee **O** Alcohol **O** Recreational Drugs
O Black Tea **O** Sugar **O** Artificial sweeteners **O** Marijuana **O** Occupational Hazards
Other:_____________________________

Exercise:
O Never **O** Little **O** Moderate **O** Heavy Type of exercise:__________________________
____

Emotional:
O Happy **O** Easily Irritable **O** Difficulty Making Decisions **O** Angry **O** Cry easily **O** Stressed
O Hurry to do things **O** Depression **O** Restless Other:___________________________________

Diet (Typical foods eaten):
O Beef **O** Eggs **O** Cheese **O** Grains **O** Tofu **O** Pork **O** Bread **O** Margarine **O** Fried Foods
O Yogurt **O** Poultry **O** Milk **O** Ice Cream **O** Sweets **O** Fish **O** Butter **O** Vegetables **O** Salads
O Health Foods **O** Diet foods **O** Spicy foods **O** Fast Foods Other:________________________

Appetite:
O Up & down **O** Poor **O** Good **O** Hungry a lot **O** Loss of taste
Do you eat 3 meals per day? **O** Yes **O** No Do you eat at regular hours? **O** Yes **O** No
Cravings:____

Weight:
O Normal **O** Underweight **O** Overweight **O** Recent gain **O** Recent Loss

Energy:
O Up & down **O** Low **O** Normal **O** excess **O** Low after eating **O** Tired in afternoon
Other:____

Body temperature:
O Warm natured **O** Flushed face **O** Feel warmer late afternoon & night **O** Sweat easily
O night sweats **O** Cold natured **O** Warm palms **O** Alternate chills & fever
O Profuse perspiration **O** cold hands & feet **O** Warm soles **O** Normal Other:______________
____

Digestion:
O Indigestion **O** Bloating **O** Heartburn **O** Nausea **O** Vomiting **O** Full feeling or distention
O Belch or burp **O** Abdominal pain or cramps **O** Gas **O** Difficulty digesting fatty or oily foods
O Bitter taste in mouth **O** Gallstones **O** Normal Other:_________________________________

Bowels:
O Loose stools **O** Diarrhea **O** Hemorrhoids **O** Constipation **O** Colon problems
O Use Laxative **O** Pain or cramps **O** Normal Other:_____________________________________

Urination: (3-4 times per day is normal)
O Frequent **O** Burning **O** Bladder infections **O** Urgency **O** Nighttime **O** Incontinence
O Kidney stones or Infection **O** Normal Other:____

Thirst:
O Less than normal **O** Prefer cold drinks **O** Thirsty but do not drink **O** Prefer hot drinks
O Excessive **O** Normal #Glasses per day_____ Other _________________________________

Sleep:
O Difficulty falling asleep **O** Lots of dreams **O** Tired in morning **O** Awake easily **O** Restless
O Nightmares **O** Sleep too much **O** Difficulty going back to sleep **O** Normal
Average # hrs a night _____ Other____

Headaches-Dizziness:
O Headaches **O** Vertigo **O** Bend down and stand up and get dizzy **O** Dizziness **O** Migraines
O Motion sickness **O** Poor balance **O** Faint easily **O** Poor memory Other_________________

Skin:
O Dry **O** Hives **O** Itchy **O** Oily **O** Acne **O** Bruise easily **O** Eczema **O** Rashes
O Cuts heal slowly **O** Normal Other____

Hair:
O Dry **O** Oily **O** Dandruff **O** Falling out **O** Early grey **O** Normal Other______________

Nails:
O Soft **O** Spots **O** Grow slowly **O** Ridges and lines **O** Purple **O** Break easily **O** Grow fast
O Pale **O** Normal Other____

Eyes:
O Wear glasses or contacts **O** Eyelids swollen **O** Red **O** Dry **O** Itch **O** Poor night vision O Pain
O Twitch **O** Sensitive to light **O** Color blindness **O** Tear easily **O** Normal Other___________

Ears:
O Poor hearing **O** Ringing (high pitch) **O** Ringing (low pitch) **O** Discharges **O** Ear aches
O Normal Other____

Nose:
O Stuffy nose **O** Hayfever **O** Sneeze a lot **O** Environmental sensitivity **O** Mucous **O** Bleeding
O Loss of smell **O** Blow nose a lot **O** Sinusitis **O** Rhinitis **O** Normal Other_______________

Mouth & Throat:
O Dry **O** Gum problem **O** Frequent colds **O** difficulty swallowing **O** TMJ **O** Thyroid problem
O Feel lump in throat **O** Grind teeth **O** Normal Other__________________________________

Respiratory:
O Shortness of breath **O** Difficulty inhaling **O** Sigh a lot **O** Chest pain **O** Difficulty exhaling
O Dry cough **O** Asthma **O** Difficulty breathing **O** Cough with phlegm **O** Bronchitis
O Wheezing **O** Emphysema **O** Cough with blood **O** Tightness in chest **O** Normal
Other____

Cardiovascular – Circulation:
O Diagnosed heart problems **O** Palpitations **O** Low blood pressure **O** High blood pressure
O Bleed easily **O** High cholesterol **O** Murmur **O** Varicose veins **O** Ankle/hand swelling
O Chest pain **O** Bruise easily **O** Irregular heart beat **O** Numbness in extremities **O** Normal
Other____

Pain:
O Low back pain **O** Shoulder **O** Muscle weakness **O** Sciatica **O** Hands or wrists **O** Mid back
O Muscle cramps **O** Upper back **O** Hips **O** Muscle twitching or spasm **O** Knees **O** Neck
O Foot or ankle **O** Nerve **O** Spine **O** Arthritis **O** Damp weather pain **O** Abdomen/ ribs/sides
Other____

Any other problem you would like to discuss?_______________________

____
____
____
____
____

Patient signature____**date**____________

***** For Females Only*****

Are you or might you be pregnant? **O** Yes **O** No **O** Maybe? Approximate date of conception___

Are you experiencing reduced sex drive? **O** Yes **O** No Other difficulties____________________
____

Do you have regular PAP tests? **O** Yes **O** No How regular?_____________________________

Do you have regular breast exams? **O** Yes **O** No How regular?___________________________

Do you have facial hair or excess body hair? **O** Yes **O** No

Menstrual Cycle:
Age started____ Days of flow____ Age stopped____

How many days from the beginning of your period to the start of your next period?_____________

Check what applies to your period:
O Irregular Cycle **O** Water retention **O** Heavy flow **O** Scanty flow **O** Dark color flow **O** Painful
O Light color flow **O** Clotting **O** Excessively painful or tender breasts **O** Breast lump
O Emotional changes **O** Spotting between periods **O** Lump in throat feeling **O** Constipation
O Diarrhea **O** Tightness in chest **O** Hormonal problems **O** Backache **O** Sigh a lot **O** Cramps
Other____

Vaginal discharge:
O Yellow **O** Thick **O** Bad odor **O** White **O** Clear Other_______________________________

Ovulation Symptoms:____
Menopause Symptoms:____
____

Pregnancies:
Total number ____ Number of miscarriages ____ Number of children ____

Pregnancy or Childbirth Complications____
____

Gynecological History and Operations:
O Ovaries____
O Uterus____
O Fallopian tubes____
O Vagina____
O Breasts____
O Other____

What method of Birth Control do you now use?____
What method of Birth control have you used in the past?_____________________________________
____

Signature:____ Date:___________________