

PATIENT INFORMATION

Name _____

Date of Birth _____

Occupation _____

Height _____ BMI _____
Weight _____

Address _____

Home _____ Work _____

Mobile _____

Marital Status _____

No. of Children: Boys _____ Girls _____

G.P. _____

Phone _____

When was your last visit to the G.P? _____

What was it for? _____

Have you seen a chiropractor? _____

Date of last adjustment? _____

Have you had Xrays in past 2 years _____

What part of your body? _____

Do you smoke? No Yes How many per day? _____

Do you drink alcohol? No Yes How much? _____

Do you take drugs? No Yes List names _____

Do you take vitamins? No Yes List names _____

Do you exercise? Regularly _____ Infrequently _____ Seldom _____

Are you pregnant? No Yes No. of Weeks _____ EDD _____ Last Period _____

Are you taking any medications? No Yes List names _____

Do you have a pacemaker? No Yes

MEDICAL HISTORY

Parents living: Father (age) _____ Mother (age) _____

Brothers: _____ Sisters _____

Family History

Mental Disease No Yes Who? _____ Asthma No Yes Who? _____

Heart Disease No Yes Who? _____ Cancer No Yes Who? _____

Lung Disease No Yes Who? _____ Arthritis No Yes Who? _____

Special Needs No Yes Who? _____ Diabetes No Yes Who? _____

Allergies No Yes Who? _____ List them _____

Any Other (specify) _____

Childhood Illness

Measles _____ Mumps _____ Chicken Pox _____ Rubella _____

Unusual Childhood Diseases _____

Immunisations No Yes List names, dates and reactions _____

Allergies (including details of anaphylaxis and how the reaction was handled)

Previous Medical Conditions (including dates)

Injuries (slips, falls, car accidents etc.) ? _____

Any back complaints? _____

Illnesses? _____

Operations? _____

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

Would you say that you are under a lot of stress? _____ If yes, explain _____

Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.?

Female: Do you experience pain or discomfort before, during or after menstrual cycle (regardless of whether you menstruate, are in menopause or have had surgical removal of all or part of the reproductive organs or skip your period occasionally)? Do you suffer from PMT? Do you suffer from PCOS? Do you suffer from irregular cycles? Do you suffer from dysmenorrhoea? Specify other.

Current Treatments

Chief Complaint (describe fully) _____

Duration of condition? _____

What do you believe caused this condition? _____

List all foods and beverages taken more than three times per week _____

Do you suffer from any of these symptoms:

B	A		B	A	
		Headaches			Excessive Gas
		Hot Flashes			Insomnia
		Blurred Vision			PMT
		Dizziness			Poor Memory
		Morning Fatigue			Sexual Impotency
		General Fatigue			Excessive Perspiration
		Laboured Breathing			Palpitation of the Chest
		Shortness of Breath			Dry Skin
		Indigestion			Poor Appetite
		Heartburn			Excessive Appetite
		Lump in the Throat			Night Sweats
		Throat Constriction			Nerves
		Numbness			Depression
		Fainting Spells			Learning Disabilities
		Light Headedness			Asthma
		Swelling of the Joints			Chemical Sensitivities
		Loose Stools			Constipation
		Candida			ADHD
		Arthritis			Pain Disorders

TO BE COMPLETED BY THE PRACTITIONER

Temperature _____

Pulse _____

Respiration _____

Blood Pressure _____

Spinal Curvature or Surgical Implants _____

General Appearance _____

Dr. Devi S. Nambudripad does not claim that any disease or illness can be cured with NAET.

I _____ understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (allopathic, chiropractic, kinesiological and acupuncture) to diagnose the patient's condition. The premise behind NAET is to desensitise a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I am (my dependant) to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after if I (my dependant) get a life threatening reaction from the allergen I (my dependant) was treated or from some other sources I need to seek emergency help immediately from a doctor qualified in emergency treatments or by calling 999 or attending Accident & Emergency Department at the local hospital. If I (my dependant) am suffering from severe allergic reactions to substances, I should consult an appropriate doctor and take appropriate medication (such as medication as to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviours) to keep my (my dependants) symptoms under control while I (my dependant) am being treated with NAET treatments. This way essential NAET treatments can be completed without interruption and once I (my dependant) complete the essential NAET treatments for my (my dependants) condition I (my dependant) may not need to continue prescription drugs indefinitely.

I understand that for 25 hours after the treatment I (my dependant) am to avoid eating, touching, breathing and coming within 5 feet or more as it was instructed by my practitioner of the substance(s) that I (my dependant) have received treatment. If I (my dependant) come in contact with the substance(s) for which I (my dependant) am being treated, I realise that the treatment may not work and I (my dependant) may have a sensitivity reaction. I understand that I (my dependant) must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if I (my dependant) have cleared the substance(s). I fully understand that I (my dependant) may still experience a reaction to the substance(s) of unknown severity if I (my dependant) come in contact with them if I (my dependant) did not clear them completely. If I (my dependant) did not clear them completely I (my dependant) may require to repeat the procedure (more treatments at my cost) until I (my dependant) clear them satisfactorily.

I give consent to **Enjoy Better Health** or Dr. Devi S. Nambudripad to use my (my ward's) diagnosis and treatment data and my (my ward's) photographs if applicable in a flyer, journals, research or other publishing purposes without revealing my real name or identity.

I confirm that I have provided you with an accurate account of my past and present medical conditions and that the treatment I am about to receive is based on that information. I have read or have had read to me the above statements and have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

Patient's/ Parent's/ _____ Print _____ Date _____
Guardian's Signature

Name of Minor _____ Relationship _____