NAET Client Information

Congratulations on your first step towards a more abundant life!

Name_____ Date: _____

Birth Date: _____ Age: ____ Sex: M F Marital Status: M W D S Spouses Name_____ # of Children:___

Address: _____ City: _____ State: _____ Zip Code: _____

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

Email address: _____ Whom may we thank for referring you to our office? _____

Reason for consulting our office today: _____

Please circle YES or NO to the following questions: Do you have allergies to; or have the following symptoms?

Animals Y N Insects Y N Welts with mosquito bites Y N Plants/ Pollens Y N Brain fog or difficulty concentrating Y N

Chemicals (cigarettes, gasoline, smoke, perfumes, cleaners, etc) Y N Foods Y N Skin reactions (rashes, eczema, hives, etc) Y N

Frequent gas or bloating Y N Frequent loose stools or diarrhea Y N Frequent phlegm in your throat or post nasal drip Y N Anxiety Y N

Frequent stuffy or runny nose when you are not sick Y N Feeling tired all the time no matter how much sleep you get Y N Frequent indigestion Y N

Do you have Mast Cell Activation disease? Y N

Please list known specific allergies_____

Do you have any health concerns that might be related to allergies? (Or unresolved health issues you may not have considered being allergy related?)

	What is it?	Date it began	Why it began	Severity 1-10, 10 is worst
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Have you seen any other professional for these health concerns? Y N

If yes, describe treatment given and the results_____

Are you unable to do things that you would normally do because of these concerns? _____

Do you have any other health conditions that we should be aware of like scoliosis or pregnancy?_____

Is there anything else that we need to know about you that were not addressed on this form?_____

Have you ever had an anaphylactic reaction? _____ To what? _____

Payment Policy

Payment is due at the time of, or previous to, services being rendered. If you have insurance you may be able to be reimbursed for part of your expenses at our office. Please circle one of each of the following:

I am	I am NOT	interested in information about insurance reimbursement.
I have	DO NOT	have Medicare. (NAET is NOT covered by Medicare.)

Missed appointments that are not cancelled or rescheduled within 24 hours of the prescheduled time are subject to a $20 fee.

Informed Consent

NAET is a specific approach that helps the body to no longer react adversely to substances that are okay for most people. After a treatment you may experience adverse symptoms, such as irritability, headaches, nausea, fatigue, or any allergic reaction for about 25 hours. You may feel worse after each visit before you feel better. It is very important that you follow the doctor's instructions to not come in contact with the allergen being treated for at least 25 hours after treatment. If you are being treated for an anaphylactic reaction, it is critical that you do not try eating, or touching that substance, until you have been tested in the office to see that you have cleared the substance. The majority of people see great improvement but we cannot guarantee results. By signing below I am consenting to receiving NAET treatments and understand I may initially feel worse after a treatment.

_____ _____ _____

Name Signature (Parent if a minor) Date

Privacy Notice

Your health information is private and protected by law. Your information will only be used or disclosed for the purpose of giving care, billing, or supporting day-to-day operations. You have the right to review your file. You may restrict all or part of your health information from being released. Our privacy manual is available at any time for you to review. A more detailed privacy policy is available that you may take with you upon request. I have had a chance to ask questions about the privacy policy and I give my permission to this office to disclose my name and, or protected health information as stated above.

_____ _____ _____

Patient Name Signature (Parent if a minor) Date

_____ _____

Witness Signature Date