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Please note: NAET does not diagnose specific allergies. We locate possible reactions to various substances Such as foods, airborne inhalants, external contactants and other stimuli that may be causing your body to react inappropriately. This is usually due to the body reacting to a harmless substance *in error*. NAET Treatments are aimed at correcting this error. We do not treat or diagnose any specific disease or condition.

NAME:_____ **DATE:**_____

Address: _____City: _____ State: _____Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Email Address: _____
Date of Birth: ____/_____/_____ Age: _____ Occupation: _____
Marital Status: _____ Emergency Contact: _____

How Did You Hear About Our Clinic? _____
_ What would you like to accomplish during your visit at the Clinic?

SECTIONS: Please Circle The Section or Sections that Apply to You and Complete Those Sections Only:
1. **Respiratory** (Nasal / Throat, Sinuses, Mouth, Chest, Eyes)
2. **Food Intolerance** (Dairy, Wheat, Corn, Veggies, Fruits, etc)
3. **Gastrointestinal** (Indigestion, Stomach Pain, Gas, Bloating, Cramps, Constipation, Diarrhea)
4. **Skin** (Rash, Eczema, Itch, Psoriasis, Redness)
5. **Contact Reactions** (Soap, Lotion, Fabrics, Chemicals, Perfumes, etc)
6. **Stimuli** (Sunlight, Cold, Heat, Weather Changes)
7. **Fatigue/Stress**

SECTION 1: RESPIRATORY MOUTH: Itch ___ Burn ___ Cold Sores ___
NASAL/THROAT
_ Mucous dripping down the back of your
Throat (Post-Nasal Drip)
_ Congestion / Stuffiness
_ Sneezing
_ Itchy nose / Itchy throat
_ Nosebleeds
_ Runny nose - what color mucous? _____
SINUSES
_ Pain/Pressure
_ Frontal Headache
_ Congestion / Fullness
_ Popping
CHEST
_ Cough
_ Shortness of breath
_ Wheezing
_ Cough with exercise
_ Cough with laughter
_ Coughing at night or when you lay down
EYES
_ Watering/tearing
_ Itching
_ Redness
_ Swelling

SECTION 2: FOOD INTOLERANCE
Foods You Suspect or Have Been Tested For:
_ Dairy: _____
_ Grains: _____
_ Corn
_ Sugar
_ Eggs
_ Meats: _____
_ MSG ____ Sulfites ____ Wines ____ Vinegar ____ Acid Foods ____ Spicy Foods ____ Shellfish_____
_ Veggies: _____ Fruits: _____
_ Coffee ____ Caffeine ____ Tea ____ Soft Drinks ____ Chocolate ____ Artificial Colors ____
_ Other: _____
SECTION 3: GASTROINTESTINAL Details:
_ Stomach Pain _____
_ Indigestion _____
_ Reflux _____
_ Heartburn _____
_ Diarrhea _____
_ Constipation _____
_ Gas / Bloating _____
SECTION 4: SKIN Details:
_ Itching _____
_ Swelling _____
_ Rashes _____
_ Hives/Welts _____
_ Dry skin _____
_ Have you had a diagnosis of: Eczema ___ Psoriasis ___ Contact Dermatitis ____
_ Other: _____
SECTION 5: CONTACT REACTIONS Details:
_ Soaps _____
_ Lotions _____
_ Fabrics _____
_ Chemicals _____
_ Perfumes _____
_ Other: _____
SECTION 6: STIMULI Details:
_ Sunlight _____
_ Cold _____
_ Heat _____
_ Weather Changes _____
_ Humidity _____
_ Motion Sickness _____
_ Air Conditioning _____
_ Other: _____
SECTION 7: FATIGUE / STRESS
_ Do you have chronic fatigue / tiredness? Yes ___ No ___
_ Do you think you ever have "Low Blood Sugar"? Yes ___ No
_ Do you have chronic 'Stress'? ( ) Severe ( ) Moderate ( ) Mild
_ Have you ever been told you have "Adrenal Exhaustion" ? Yes___
_ Have you ever been told you have "Low Thyroid" ? Yes ___
_ Other: _____
Which of the above symptoms bother you the most (Your Top Priorities**?)**
_____
SYMPTOM PROGRESSION:
_ My symptoms have been unchanged for some time.
_ My symptoms have been getting worse over the past few:
_ weeks__ months__ year
My symptoms are worse during ;
_ spring
_ summer
_ fall
_ winter _ My symptoms are **present all throughout the year, but they flare-up during** _____

PROVOKING FACTORS:
Do any of these things seem to bring on or aggravate your symptoms?
_ Trees/Pollens
_ Dust/Molds
_ Dog/Cat/Other animals
_ Tobacco smoke
_ Weather changes
_ Cold air/Air conditioning
_ Chemicals/Perfumes
_ Exercise or Physical exertion
_ Laughter
_ Foods? Which ones?_____

ALLERGY HISTORY:
Have you been treated for allergies in the past?
_ No
_ Yes
Did you see an allergist? _ **NO** _**YES** Doctor?_____
What kind of testing was done? Where? _____
_ Skin testing
_ Blood testing (RAST)
When was testing done?_____
What were the results?_____
_____
What type of treatment was recommended?_____
_____
If you were placed on allergy shots, how long were you on them?_____
Did they help with your allergies? _ **NO** _ **YES**
Did you have any significant reactions to your allergy shots? _ **NO** _ **YES, please explain**:_____
_____

MEDICATION HISTORY:
Please list **prescription** allergy medications you are **currently taking**. Please include all pills, eye drops, nasal sprays and lung sprays.
MEDICATION DOSE HOW OFTEN DOES IT HELP? SIDE EFFECTS
_____
_____
_____
_____
Please list **over-the-counter** allergy medications / Herbs (non-prescription) you are currently taking.
MEDICATION DOSE HOW OFTEN DOES IT HELP? SIDE EFFECTS
_____
_____
_____
Please list any other medications you have taken in the past (those not listed above)
_____
_____

GENERAL MEDICAL HISTORY:
Who is your primary doctor or family physician? _____ City:_____
Are you allergic to any medications?
_ No
_ Yes; I am allergic to:_____
What type of reaction did you have?_____
Have **you** been diagnosed with any of the following medical conditions?
ASTHMA _ No _ Yes
HIGH BLOOD PRESSURE _ No _ Yes
ELEVATED CHOLESTEROL _ No _ Yes
GASTROESOPHAGEAL REFLUX (GERD) _ No _ Yes
DIABETES _ No _ Yes
LIVER DISEASE/HEPATITIS _ No _ Yes
SEXUALLY TRANSMITTED DISEASE _ No _ Yes
GLAUCOMA _ No _ Yes
OTHER:_____

SMOKING HISTORY:
_ I have never smoked.
_ I stopped smoking _____ years ago. I used to smoke _____ pack(s) a day for _____years.
_ I am a smoker now and smoke about _____pack(s) per day.
_ I do not smoke but I am frequently exposed to second hand smoke at _____.

SURGICAL HISTORY:
_ I have not had any surgeries.
_ Yes, I have had:
_ Tonsils Date:_____
_ Adenoids Date:_____
_ Nasal/Sinus surgery Date: _____ Surgeon:_____
_ Other Surgery:_____ Date:_____
Were there any complications associated with your surgery, including the anesthesia used?
_ No
_ Yes; please explain._____
IMAGING STUDIES (XRAYS):
_ None
_ Sinuses Date: _____ Results:_____
_ Chest Date: _____ Results:_____
_ Other _____ Date:_____ Results:_____
FAMILY HISTORY:
Does anyone in your family have any of these conditions?
_ Hayfever Who?_____
_ Sinus problems Who?_____
_ Skin rashes/facial or lip swelling Who?_____
_ Asthma Who?_____
_ No one in my family has allergies.
MATERNAL (Mother) HISTORY:
_ Living AGE:_____ Any medical problems? _ No _ Yes; _____
_ Deceased at age:_____ Cause of death:_____
PATERNAL (Father) HISTORY:
_ Living AGE:_____ Any medical problems? _ No _ Yes;_____
_ Deceased at age:_____ Cause of death:_____
Do you have any children? _ No _ Yes.
Do they have any medical or Allergy problems? _ No _ Yes: _____
_____
Would you like to discuss your children's health concerns with the doctor? _____
_____
ENVIRONMENTAL HISTORY:
Do you live in a:
_ House
_ Apartment
_ Townhouse/Condo/Duplex
Have you EVER had **Mold** in your house? Basement? ___ Bathroom? ___ Windows? ___ Attic? ____
Does anyone in the house smoke? _ No _ Yes
Is there smoking in the bedroom _ No _ Yes
Do you have any **pets?** _ No _ Yes, I have: _____
Are they allowed to come in the bedroom? _ No _ Yes
Are they bathed? _ No _ Yes
What type of heating do you have in the house?
_ Central furnace with forced-air heating
_ Wall heaters
_ Radiant-heating system
How old is the system?_____ years old.
_ Is heating system is new.
Has the system been professionally cleaned?
_ Yes, how long ago?_____
_ Not since I've lived in the house.
_ I don't know.
Are there special allergy filters in the heating system? _ No _ Yes
Do you have air-conditioning? _ No _ Yes

BEDROOM
Do you have carpeting in the bedroom? _ No _Yes
I have _____floors in the bedroom.

Do you sleep on any type of feather bedding?
_ No
_ Yes _ Pillow _ Down comforter _ Feather bed
Do you sleep on a waterbed? _ No _ Yes
Do you have an air-purifier in the bedroom? _ No _Yes, it runs _____hours a day.

LIFESTYLE:
Have your allergies affected your work, relationships or your recreational activities?
_ No
_ Yes, please explain._____
_____

ADDITIONAL COMMENTS:
Please use this space to expand on any issues you would like us to be aware of:
_____
_____

Patient Signature: _____ Date: _____
****If Patient is a Minor Child, Parent or Guardian Please Sign to Authorize Care/Treatment of Minor****

Name of Minor Child: _____ Age: _____

Parent Signature to Authorize Care: _____ Date: _____

FOR OFFICE USE ONLY
AirB: ____ Food: ____ GI: ____ Skin: ____ Cont: ____ Stim: ____ Fatigue: ____ Endocrine: ____