REGISTRATION FORM

Today's date:

PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Address:			City:		Zip Code:	
Year moved to Utah:	Other places lived:	Place of Birth:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Any prior experience with NAET? If so, by whom?		Ethnicity:		Home phone no.: ( )		
Highest grade completed:	Cell Phone		Email:			
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.				
❑ Family	❑ Friend	❑ Close to home/work	❑ Naet website	❑Other		
Other family members seen here:						

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone # ( )	Work phone # ( )
Patient/Guardian signature		*Date*	

Major Health Concerns, In Order of Importance for You:

Complaint	Since When	Causes (Known or Suspected)

What other treatments, diets or regimes are you currently following?

Treatment or Regime & Practitioner if Any	Since When	Results

When were you last seen by a physician? _____ What were you seen for? _____

Date of last physical exam if different from above. _____Do you go for an annual physical? _____

Doctor's name _____ Specialty _____

Have you had any recent diagnostic testing or labs or x-rays? _____

Have you been diagnosed with any diseases?	Since when?

Recent Surgeries or Hospitalizations:

Name and Location	Date	Reason

Are you currently taking any medication, herbs or supplements?

Medication	Since When	Results/Adverse Effects

Immunizations / Vaccinations	When	Any adverse reactions?.

Members of household (Including Pets):

Name	Age	Relationship

Family History

Please circle any of the following conditions that have affected your blood relatives:

Alcoholism	Bleeding Disorder	Epilepsy/Seizures	Kidney Disease	Schizophrenia
Allergies	Brain Tumors	Gonorrhea	Learning Disabilities	STD's (_____)
Anemia	Cancer (_____)	Gout	Mental Illness	Skin Diseases
Aneurysms	Cerebral Palsy	Hay Fever	Mental Retardation	Stroke
Anxiety	Chemical Dependency	Headaches	Migraines	Syphilis
Arthritis	Depression	Heart Disease	Muscular Disease	Thyroid Disease
Asthma	Diabetes	Hepatitis	Obsessive Compulsive	Tics
Bipolar Disorder	Eczema	High Blood Pressure	Paralysis	Tuberculosis

Relative	Age If Alive	Age at Death	Major Ailment or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			

Significant family deaths and their age of death. Have any particular losses have a great impact on you or your family?

Personal History

Which of the following conditions have you had? Mark a P (past) or a C (current).

Abscesses		Cancer (type)		Gonorrhea		Irritable Bowel Syndrome	
AIDS		Cataracts		Gout		Kidney Disease	
Alcoholism		Chemical Dependency		Hay Fever		Liver Disease	
Allergies				Headaches		Malaria	
Anemia		Chicken Pox		Heart Disease		Measles	
Anorexia		Depression		Heart Murmer		Memory Problem	
Appendicitis		Diabetes		Hepatitis		Migraines	
Arthritis		Eczema		Hernia		Miscarriages	
Asthma		Emphysema		Herpes		Mononucleosis	
Bleeding disorder		Epilepsy		High Blood Pressure		Mumps	
Breast lump		Gall Stones		High Cholesterol		Overweight	

Bronchitis		Glaucoma		HIV positive		Pacemaker	
Bulimia		Goiter		Hypoglycemia		Parasites	
Pneumonia		Scarlet Fever		Suicide Attempts		Ulcers	
Polio		Sexual Abuse		Thyroid Problems		Vaginal Infections	
Prostate Problem		Physical Abuse		Tonsilitis		Sexually Transmitted Disease	
Psychiatric Care		Skin Disease		Tuberculosis		Whooping Cough	
Rheumatic Fever		Stroke		Typhoid Fever		Yeast Infections	

Are you still experiencing any problems or long term effects from any of the above conditions? Did you require medical treatment or are you currently under medical care for it?

Any other major conditions or abnormalities?

What major injuries have you had and when? Any long-term effects?

Have you had any unusual childhood diseases? Yes /No Type of disease:

Any anaphylactic or life threatening allergies?	Reactions

List known or suspected allergies.	Reactions

Current Symptoms (Severity on a scale of 1-10)

Headaches		Throat constrictions		Sexual impotence	
Hot flashes		Numbness		Excessive perspiration	
Blurred vision		Fainting spells		Palpitations of the chest	
Dizziness		Light headaches		Dry skin	
Morning Fatigue		Swelling of the joints		Poor appetite	
Labored Breathing		Loose stools		Excessive appetite	
Shortness of Breath		Excessive Gas		Night Sweats	
Indigestion		Insomnia		Nerves	
Heartburn		PMS		Depression	
Lump in the throat		Poor memory		Learning disabilities	
Asthma		Chemical Sensitivities		Constipation	
Forgetfulness		Worry		Poor memory	
Failing memory		Difficulty concentrating			

Lifestyle

Do you smoke? Yes / No How many per day/week? _____
Do you drink alcohol? Yes / No How much? How often? _____
Do you drink coffee? Yes / No How much? How often? _____

Do you take any recreational drugs? Yes /No Have you ever taken any recreational drugs? Yes /No
Which ones? _____ Which ones? _____

Do you exercise? Yes / No Type of exercise _____
How often (# times per week and for how long?)_____

Have you traveled abroad? Yes /No Where?
_____

Do you have any hobbies?
How would you describe your personality type: Do you consider yourself a perfectionist or are you more relaxed. Are you frequently late for deadlines or have difficulty dealing with stress in your life?

While not always apparent, better or worse health is intricately interwoven with the easier or harder stresses and life events. Consider including any of the following: traumas or injuries, strong specific memories, job stressors, marital or relationship stressors, physical stresses, injuries or traumas to a family member that is impacting you… Any birth related traumas or early childhood challenges that you still remember or your parents talk about.

Age or Year	Stresses and Life Events	Any changes in physical health or emotional health.

Do you consider yourself to be under a lot of stress currently? If so, explain.

Diet

How many meals do you have a day? _____.

Typical Breakfast	Typical Lunch	Typical Dinner	Typical Foods on the Weekends if different from during the week

Are there any foods that you have a strong aversion or craving for? (Sweets, chocolate, salty, sour, carbs, rich/fatty, spicy, cold, hot, bitter.)

Describe any other important or interesting notes regarding the food and drink category, that is unique to you.

Do you have any problems with constipation? If yes, for how long? How frequently do you have a bowel movement? What is the consistency?

_____

Do you have any problems with urination? Frequency/ Urgency / Pain?

_____

Have you gained or lost any weight in the past 6 months? Yes /No Was it intentional? How many pounds?

_____

Current Height: _____

Current Weight: _____

I have read the Instructions To A New Patient Before Beginning Treatment and I have had the opportunity to have all my questions about it clarified. I agree to follow these instructions in order for the treatments to be effective and I also realize that it may take more than one treatment to clear certain allergies.

Signature of the patient/guardian ———————————————— Date ————————

Print Your name ————————————————————————————————

Witness ————————————————————Date ————————————

Payment Is Due At Time Of Service

I understand that I am financially responsible for all charges.

Signed: _____ Date: _____

FOR WOMEN ONLY

Please describe your menstrual cycle. If you are no longer menstruating, please describe your cycle before menopause.

Age at first period _____ Age at menopause (if applicable) _____

Are you currently pregnant? _____ Date of last menstrual period (first day of bleeding) _____

How many days is your cycle (from the first day of bleeding to the first day of bleeding)? _____

For how many days do you bleed (menstruate)? _____

Is your flow light, medium, or heavy? _____

Do you spot between periods? (Y/N)

Are your periods regular? (Y/N) If not, please describe.

Do you have cramping? (Y/N) If so, does cramping occur before, during, or after menstruation? _____

Please describe the location and nature of the pain.

If you have experienced menopause, please describe any menopausal symptoms, indicating whether they are current or past symptoms.

Have you ever used hormone replacement therapy (HRT)? (Y/N)

If so, please list dates _____ and medications used _____

_____ _____

_____ _____

Have you ever been pregnant? (Y/N) If so, how many times? _____

Please give the dates of your deliveries _____ miscarriages _____ abortions _____

_____ _____ _____

_____ _____ _____

Were there any problems with your deliveries, miscarriages, or abortions? (Y/N) If so, please explain.

Did your mother ever take DES? (Y/N)

Are you currently using birth control? (Y/N)

If so, for how long have you used this method? _____

If so, please describe your current method of birth control.

Please list any past methods of birth control that you have used.