NAET Virginia

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NAETVirginia.com

GENERAL INFORMATION:

Date_____

Name _____ Date of Birth_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____

E-Mail_____

Occupation_____ Employer_____

Status: S M D W Sep Spouse/Partner Name_____

Emergency Contact _____ Phone_____

Who may we thank for referring you?

_____

MEDICAL HISTORY:

Please circle all conditions that apply and indicate any medications taken below:

Fibromyalgia
Thyroid Disease
HIV/AIDS
Digestive disorders
Breathing problems
High blood pressure
Cancer
Kidney disease
Ulcer
Arthritis
Neuromuscular disease
Psychological challenges
Hepatitis
Seizures
Venereal disease
Tuberculosis
Heart disease or Stroke
High Triglycerides
Lung disease
Osteoporosis
Diabetes Mellitus
Anemia
Gallbladder disease
Other (please specify):_____

Surgeries - please include year performed:

_____

Hospitalizations: _____

Significant Trauma:

_____

Known Allergies:

_____

FAMILY MEDICAL HISTORY: (please specify family member)

_____Cancer	_____Diabetes	_____Hepatitis
_____Hypertension	_____Heart disease	_____Stroke
_____Asthma	_____Alcoholism	_____Miscarriage
_____Autoimmune disease	_____Other	

MEDICATIONS:

Please list any medications you have taken within the last two (2) months. Include vitamins, OTC drugs, herbs, etc. and dosages. (use back of page if necessary)

OCCUPATION:

Do you usually work indoors or outdoors?
Occupational stressors (chemical, physical, psychological, etc):

PERSONAL:

Height: _____ Weight: _____

HABITS:

Do you smoke? _____ How much per day? _____ Since when? _____
Please describe any use of drugs for non-medical purposes:

Do you exercise regularly? _____
How many hours do you sleep in general? _____

NUTRITION:

Do you drink caffeinated beverages? If so, how many per day?_____
Do you drink alcoholic beverages? If so, how many per week?_____
How much water do you drink per day? _____

Please describe your typical daily diet by indicating servings eaten of each group below:

_____glasses of water _____fruits _____vegetables

_____meats _____fast food _____coffee/tea/soda

_____breads/grains/pastas

COMPLAINTS: (please circle all that apply)

Head
Headaches
Migraines
Dizziness
Memory Loss
Unusual tastes
Rapid Heart Beat

Eyes
Blurred vision
Pain
Dryness
Glasses
Eyestrain
Color Blindness
Night blindness
Cataracts
Spots in front of eyes

Ears
Poor hearing
Ringing
Frequent ear infections

Nose
Frequent colds
Sinus trouble
Allergies
Nosebleeds
Drainage

Gastrointestinal
Poor appetite
Bad breath
Excessive Hunger
Excessive Thirst
Belching or Heartburn
Gas
Abdominal pain/cramps
Parasites
Nausea
Constipation
Chronic laxative use
Loose stools or diarrhea
Blood in stools
Black stools
Hemorrhoids
Rectal pain
Stomach pain
Colitis or IBS
Gallbladder trouble

Mouth
Gum Problems
Teeth Problems
Tongue/lip sores
Jaw clicking/pain
Palpitations

Throat
Difficulty swallowing
Sore throat
Enlarged thyroid

Respiration
Asthma
Bronchitis
Chest pain
Cough
Coughing blood
Difficulty breathing
Phlegm
Pneumonia
Wheezing
History of smoking

Men's issues
Prostate problems
Discharge
Impotence
Frequent seminal emissions
Fertility problems
Ejaculatory problems
Painful/Swollen testicles

Womens's issues
Painful menstrual cycles
Cramps or backache
Fertility problems
Ovarian cysts
Excessive flow
Endometriosis
Light flow
Clotting
Irregular cycle
Hot flashes
Vagina discharge

Heart and Thorax
Low blood pressure
Tightness in chest
Arteriosclerosis
Prior heart attack
High blood pressure

Circulation
Bruise easily
Cold hands/feet
Fainting
Phlebitis
Varicose Veins
Anemia

Skin
Rashes
Change in skin/hair
Dryness
Dandruff
Eczema
Hair loss
Hives
Itching
Night sweats
Pimples
Recent Moles
Excessive sweating

Emotional
Depression
Mania/Bipolar
Anxiety
Bad temper
Mood swings
Stressed

Neuromuscular
Stiff neck
Low back soreness
Shoulder trouble
Spinal curvature
Knee trouble
Pain mid back
Swollen joints
Painful joints
Hip pain
Arthritis
Hand/wrist pain
Knee pain

Urogential
Frequent urination
Difficulty urinating
Burning urination
Frequent UTI's
Waking to urinate
Retention of urine
Dribbling of urine
Bedwetting
Pause of flow-urination
Itching of genitals

Sleep
Insomnia
Drowsiness
Night sweats
Sleepwalking
Excessive Dreaming
Not enough

Fibrocystic breasts
Breast tenderness
PMS
Abnormal bleeding
Low sex drive
# of pregnancies____
# of births_____
# of miscarriages
# of abortions

Energy Level
Low energy
Excessive energy
Hard to wake up
Energy drop in afternoon
Sudden energy drops

Sprain
Hernia
Sciatica
Numbness
Paralysis

I have had an anaphylactic or other severe allergic reaction to the following substances:

I have been medically diagnosed for the following allergies/asthma: