DeHart Chiropractic
NAET
New Patient Information

Patient Information

Name:_____ D.O.B:_____
Address:_____
_____
Phone #:_____ Email:_____
Occupation:_____ Employer:_____ Student: Yes___ No___

Family History

Is there any family history of:

Diabetes_____ Asthma_____
Cancer_____ Mental Disease_____
Heart Disease_____ Lung Disease_____
Arthritis_____ Allergies_____
Any other (specify)_____

Past History

List any past significant illnesses_____
Are you taking any medications now? Yes_____ No_____
List any known allergies_____
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 you are under a lot of stress?_____ If yes, explain_____
_____
Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.?_____
Females: Do you experience any pain or discomfort before, during or after menstrual cycle? Do you experience any discomforts during the cycle week (regardless of whether you menstruate, are in menopause, or have had surgical removal of part or all of the female reproductive organs, or skip your periods periodically.) During the week are you "grouchy"? Irritable? Have crying spells? Feel uptight? More nervous? Or specify any other problems_____
_____

Do you suffer from any of these symptoms?

_____headaches
_____hot flashes
_____blurred vision
_____dizziness
_____morning fatigue
_____general fatigue
_____labored breathing
_____shortness of breath
_____indigestion
_____heartburn
_____lump in the throat
_____throat constriction
_____numbness
_____fainting spells
_____light headedness
_____swelling in joints
_____loose stools
_____excessive gas
_____insomnia
_____PMS
_____poor memory
_____sexual impotency
_____excessive perspiration
_____palpitation of the chest
_____dry skin
_____poor appetite
_____excessive appetite
_____night sweats
_____nerves
_____depression
_____learning disabilities
_____asthma
_____chemical sensitivities
_____constipation

Other: _____

_____

Chief Complaint

Describe present complaint fully:_____

_____

Duration of present illness:_____

What do you believe caused this condition?_____

_____

If due to an auto or work injury, please explain:_____

_____

When were you last seen by a physician?_____

For what purpose?_____

Dr's name_____ Specialty_____

Who may we thank for referring you?_____

PAYMENT IS DUE AT THE TIME OF SERVICE

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also agree that a photocopy of this assignment is to be as valid as an original.

Patient signature:_____ Date:_____

(parent or guardian if patient is minor)

NAET Consent Form

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 patients condition. The premise behind NAET is to desensitize 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 dependent) to continue all medications and other treatment modalities as they have prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours, or after, if I (my dependent) get a life-threatening reaction from the allergen I (my dependent) was treated or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital. If I (my dependent) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my dependents) symptoms under control while I (my dependent) am treating with NAET treatments. This way essential NAET treatments can be completed without interruption and once I (my dependent) complete the essential NAET treatments for my (my dependents) condition, I (my dependent) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my dependent) 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 dependent) have received treatment. If I (my dependent) come in contact with the substance(s) for which I (my dependent) am being treated, I realize that the treatment may not work and I (my dependent) may have a sensitivity reaction.

I understand that I (my dependent) must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if I (my dependent) have cleared for the substance(s). I fully understand that I (my dependent) may still experience a reaction to the substance(s) of unknown severity if I (my dependent) come in contact with them if I (my dependent) did not clear them completely. If I (my dependent) did not clear them completely, I (my dependent) may require repeating the procedure until I (my dependent) clear them satisfactorily.

I have read, or have had read to me the above statements, and I have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

_____ _____

Patient's signature Date

_____ _____

Name of the minor Relationship to minor

_____ _____

Signature of Witness Date