

Do you Currently (C) have or have you in the Past (P); had any of the following health conditions?:

Please indicate with a circle on **C**-or **P** or both as applicable:-

Bloating C/P **Irritable bowel** C/P **PMT** C/P **Arthritis** C/P **Candida** C/P

Sinusitis C/P **Headaches** C/P **Migraine** C/P **Hay fever** C/P **Frequent colds** C/P

Digestive problems C/P **Chronic fatigue** C/P **Skin problems** C/P

Do you currently suffer or have suffered from any serious illnesses?

If yes, please give details.

What major physical or emotional traumas have you suffered in the last 5-10 years?

Have you ever been a smoker? YES NO If yes, do you still smoke? YES NO If no, when did you stop?

Do you drink alcohol? YES NO If yes, how many units do you drink per day or per week?
(1 unit = a glass of wine; or a single spirit, or ½ pint of beer or cider)

What supplements and/or non-prescription medication do you take?

Please tick all vaccines and childhood/teenage illnesses you recall:

Vaccination

- Chicken Pox
- Cholera
- Diphtheria
- German Measles
- Hepatitis
- Malaria
- Measles
- Mumps
- Polio
- MMR

Illness

- Chicken Pox
- Cholera
- Diphtheria
- German Measles
- Hepatitis
- Malaria
- Measles
- Mumps
- Polio
- Glandular Fever

Vaccination

- Scarlet
- Fever
- Scarletina
- Smallpox
- Tuberculosis
- Tetanus
- Typhoid
- Whooping Cough
- Yellow Fever
- Other

Illness

- Scarlet
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- Smallpox
- Tuberculosis
- Tetanus
- Typhoid
- Whooping Cough
- Yellow Fever
- Other

Do you have any amalgam fillings, root canals, dentures, gold crowns? Please underline.

What long-term courses of antibiotics have you been prescribed?

LIFESTYLE

What is your occupation/type of work?

Hours of work:

How long have you been in your present job?

Does it provide you with job satisfaction?

On a scale of 1 to 10, how would you describe your stress level? (10 being highest)

On a scale of 1 to 10, how would you describe your energy level?

How would you describe your quality of sleep:-

What are your hobbies and/or interests?

Do you have or have you ever had any pets ?

DIET (NUTRITION):

How many main meals do you have per day?

How much fresh fruit & vegetable do you eat per day?

What are your FOOD CRAVINGS? Please describe.

Which FOODS do you eat MORE THAN 3 TIMES per week?

Which are your FAVOURITE FOODS?

Which FOODS do you eat LESS THAN 3 TIMES per week?

Which FOODS do you particularly AVOID? Please give reasons.

Which FOODS do you really DISLIKE? Please give reasons.

Haw many cups of beverage do you drink per day?

Tea = Coffee = Herbal Tea = Other =

How much WATER do you drink per day? (glasses or litres)

Please add any other information you feel is relevant to your condition and which might help me in deciding on an appropriate treatment protocol. (Continue on a separate sheet if necessary):

How did you hear about NAET Allergy Therapy?

What are your expectation(s) of any NAET treatment protocol undertaken?

(OPTIONAL) *(No contact will be made without your prior knowledge and permission)*

Doctor's name:

Surgery address:

Telephone contact:

I confirm that the information I have provided is correct to the best of my knowledge.

Signature

Date:-