



**CONFIDENTIAL**

**HISTORY**

**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	Illness	Vaccination	Illness
	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scarlet	<input type="checkbox"/> Scarlet
<input type="checkbox"/> Cholera	<input type="checkbox"/> Cholera	<input type="checkbox"/> Fever	<input type="checkbox"/> Fever	
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Scarletina	<input type="checkbox"/> Scarletina	
<input type="checkbox"/> German Measles	<input type="checkbox"/> German Measles	<input type="checkbox"/> Smallpox	<input type="checkbox"/> Smallpox	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Malaria	<input type="checkbox"/> Malaria	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Measles	<input type="checkbox"/> Measles	<input type="checkbox"/> Typhoid	<input type="checkbox"/> Typhoid	
<input type="checkbox"/> Mumps	<input type="checkbox"/> Mumps	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Whooping Cough	
<input type="checkbox"/> Polio	<input type="checkbox"/> Polio	<input type="checkbox"/> Yellow Fever	<input type="checkbox"/> Yellow Fever	
<input type="checkbox"/> MMR	<input type="checkbox"/> Glandular Fever	<input type="checkbox"/> Other	<input type="checkbox"/> 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.**

**How 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)**

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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 ):

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How did you hear about NAET Allergy Therapy?

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

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(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:-