NEW PATIENT ADMISSION FORM

PATIENT HISTORY FORM - (Please print legibly)

Wildflower
ALLERGY AND HERBS
Treating Allergies Through NAET and Herbal Remedies

Date:

File No. _____

Name_____Day/night Phone (____) _____
Res. Address_____ City_____ State _____ Zip _____
Date of Birth_____Age_____ Sex: M _____ F_____ Height _____ Weight _____
Employer_____Occupation_____ Work phone# _____
Address_____City_____State_____Zip _____
Driver's License #_____State_____Exp. Date _____
Marital Status M S D W No. of Children: [ ] Boys_____Girls_____ S.S# _____
Name of Spouse_____Referred by _____
Spouse's employer (name, addresss, city, phone) _____
Person financially responsible (if patient is a child, fill out above work information etc., for parent.)
Spouse's Occupation_____ Contact in Emergency_____ Phone _____
Medical Insurance: Yes_____ No_____ Insurance Co. Name_____

Consent To Treatment

I _____ hereby consent, authorize and request Drs. Nambudripad (listed above) to administer the treatment deemed advisable and necessary to my (my ward's) condition in accordance with his/her expertise. I agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from such treatment.

Patient's Signature _____ Print Name _____ Date. _____

Witness _____Print Name. _____Date. _____

Family History:
Age of family members: Father_____ Mother_____Brothers_____ Sisters _____
Is there any family history of : Allergies _____ Diabetes_____ Hypoglycemia _____
Asthma _____ Cancer _____ Mental disease _____ Lung disease _____
Heart disease_____ Skin issues_____ Hypertension _____ Arthritis_____
Mercury toxicity? _____ Hormone issues_____ Heavy metal toxicity? _____
Severe Yeast Infections? _____
Any other health problems? _____
Please list any information about your mother's health status while pregnant with you, inlcuidng medications, illnesses and diagnoses _____ _____
_____
Did your mother smoke or use drugs during pregnancy?_____

Personal History: Have you had any of the following diseases: Measles_____ Mumps_____
Chicken pox_____ Rubella_____ Scarlet fever _____ Polio_____ TB_____
Unusual childhood diseases_____
Immunizations _____ List the names and give the dates_____
_____
_____
Any severe reaction after immunizations? _____ Describe _____
Any severe reactions to other drugs? _____ Describe _____
__ _____
Please state any unusual events that happened during childhood that may be associated _____
_____
Describe the situation. _____
Any other problems?_____
Do you have any mechanical devices (like shunts, hearing aids, pacemaker, ear tubes, implants, etc.) ___
_____
Are you pregnant now? Yes [ ] __No [ ] - Last Menstrual Period_____

Have you had any problems in the past with pregnancies?_____
_____

How often do you exercise? Regularly__ Infrequently__ Seldom__ What type of exercise? _____
_____

Hobbies if any _____

Past History: List any previous significant injuries (slips, falls, auto accidents, etc.) and give dates, incluidng during childhood_____
_____
List any past significant illnesses _____ _____
__ _____
List all operations (Give dates.) _____
_ _____ _____

Are you taking any medications now ? yes_____ No_____ List all names on page 5.
List any known allergies _____
__ _____
List all abnormalities _____
Have you seen any chiropractor before? yes_____ No_____ Last adjustment_____
Name and address of your Chiropractor_____
Have you seen any Acupuncturist before? yes_____ No_____ Last Treatment_____
Name and Address of your Acupuncturist _____
Reason for Acupuncture Treatment _____.
Last physical exam_____ Date _____Findings _____
Where? _____ Reason _____
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._____
_____

Do you suffer from any of these symptoms: **(Before=B; After NAET (A)**

B	A		B	A	
____	____	Arthritis	____	____	Excessive gas
____	____	Headaches	____	____	Insomnia
____	____	Hot flashes	____	____	PMS
____	____	Blurred vision	____	____	Poor Memory
____	____	Dizziness	____	____	Sexual impotency
____	____	Abdominal Pain	____	____	Excessive perspiration
____	____	Fatigue	____	____	Palpitation of the chest
____	____	Labored breathing	____	____	Dry skin
____	____	Shortness of breath	____	____	Appetite problems
____	____	Indigestion	____	____	Weight loss
____	____	Heartburn	____	____	Night Sweats
____	____	Lump in the throat	____	____	Nerves
____	____	Throat constriction	____	____	Depression
____	____	Numbness	____	____	Fever
____	____	Fainting spell	____	____	Asthma
____	____	Light headedness	____	____	Chemical sensitivities
____	____	Swelling of the joints	____	____	Constipation
____	____	Loose stools	____	____	ADHD
____	___	Candida	____	____	Autism
____	____	Learning Disabilities	____	____	Pain Disorders
____	___	Weight gain			

Any history of Anaphylaxis? Yes [ ] No [ ] If Yes list the items. _____
List the dates, place, and on the items you had anaphylaxis. _____ ___
_____
How did you handle the reaction? _____
Explain : _____
Any other problems not listed above. _____ ____
_____

Rajsree Nambudripad, MD
Devi Nambudripad, MD, DC, LAc, PhD
Roy Nambudripad, MD

What is your main problem:_____ _____
_____
Describe the problem fully please _____
_____
How long have you had the problem_____ ____
_____
What do you believe caused this condition? _____
_____
Is your condition due to accident? yes [ ] No [ ] or Illness? Yes [ ] No [ ]. If Illness please explain. _____ _
_____

If due to auto accident or injury at work, please specify _____
_____
When were you last seen by a physician? _____
For what purpose? _____
Your current doctor's name _____Specialty_____
Address _____ City _____State _____ Zip_____
Telephone no. _____Diagnosis by your doctor _____

RELEASE FORM

I give my consent to Kerri Ballinger, NAET Practitioner (listed above) to use my (my ward's) lab results, diagnosis, treatment data and my (my ward's) photographs if applicable in a flyer, journals, research or other publishing purposes without revealing my real name.

Patient's Signature:_____ Print _____Date: _____

_____ _____ _____
Name of the Minor Relationship to the ward (mother/father/guardian/husband/wife)

_____ _____
Parent's /guardian's Signature Date
Signature of Witness _____ Print name _____ Date _____

Rajsree Nambudripad, MD
Devi Nambudripad, MD, DC, LAc, PhD
Roy Nambudripad, MD

PAIN CLINIC NEW PATIENT MEDICAL QUESTIONNAIRE

HEALTH GOALS
Please list below your health goals.

CURRENT HEALTH PROBLEMS AND PRIOR TREATMENTS
Please list below your current health problems in order of severity and describe any past treatments.

CURRENT MEDICATIONS AND SUPPLEMENTS
Please list all medications, vitamins and herbal supplements. Include doses if you know them.

DIET
Please describe your typical breakfast, lunch, dinner, snacks, and choice of beverages.

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

LIFE STRESSORS
Please describe any past and present life stressors. For example, include any traumatic life events, stress from relationships, stress from work, and financial hardships.

OTHER IMPORTANT INFORMATION FOR YOUR DOCTORS TO KNOW
Please elaborate on anything you feel is important to you and your care.

I,_____, certify that Kerri Balliner, NAET Practitioner (as listed above) do not claim to cure any illnesses or diseases with NAET® (Nambudripad's Allergy Elimination Techniques).

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 subtance(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 a patient's condition. The premise behind NAET® is to balance the energy of the individual patient to a substance(s) using NAET® (this procedure uses information from allopathic, chiropractic, acupuncture/acupressure, nutritional, and applied kinesiology) so that the patient may not experience hypersensitive symptoms when they have future contact with that substance(s).

I understand that I am (or my dependent is) to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after, if I (or my dependent) develop a life-threatening reaction from the allergen that I (or my dependent) was holding during NAET® Energy Balancing Procedures (EBP) or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency care, or by calling 911. If I am (or my dependent is) 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, asthma, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (or my dependent's) symptoms under control while I am (or my dependent is) going through NAET® EBP . This way NAET® EBP program can be satisfactorily completed on the basic allergens without interruption and once I (or my dependent) complete NAET® EBP for my (my dependent's) condition, I (or my dependent) may experience a reduction in allergic symptoms and improved quality of life.

I understand that for 25 hours after the NAET® EBP, I am (or my dependent is) 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 EBPfor. If I (or my dependent) come in contact with the substance(s) for which I (or my dependent) am being energy balanced, I realize that the EBPmay not work and I (my dependent) may have a sensitivity reaction.

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

After the successful completion of my NAET® EBP program I give permission to the pain clinic to use my (my ward's) case study in educating other similar patients or accumulating data for research purpose without disclosing my real name or address. I give permission to take photographs of my (my ward's) diseased body part (e.g.. in case of skin problem, etc.) to use in research or patient education purpose without disclosing my real name or address.

I have read or have had read to me the above statements and 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 the ward (mother/father/guardian/husband/wife)

_____ _____