Patient Registration and Personal History

Patient Full Name: ______________________________ **DOB:** __________ **Age:** ______

Sex: ☐ female ☐ male **Marital Status:** ☐ single ☐ married ☐ separated ☐ divorced

Home Phone: ______________________ **Cell Phone:** ______________________

Work Phone: ______________________ **Other Phone:** ______________________

Email Address: ____

Address: ____

City, State, Zip: ____

Immediate Family (list members of household with their ages):

Spouse: ______________________ ______________________

______________________ ______________________

______________________ ______________________

Education (check highest achieved): ☐ grade school ☐ high school ☐ college ☐ other

Occupation: ______________________ **Employer:** ______________________

Referred By: ______________________________

Responsible Party (if not patient):

Full Name: ______________________________Sex: ______ Age: ______

Relationship to Patient: ______________________

Address: ____

City, State, Zip: ____

Home Phone: ______________________ Cell Phone: ______________________

Email Address: ____

Chief Complaint: ____

Patient Name: ____

Past Health

Childhood Illnesses: ☐ measles ☐ German measles ☐ chicken pox ☐ mumps ☐ other

Vaccinations: ☐ smallpox ☐ tetanus ☐ DPT ☐ polio ☐ measles ☐ German measles ☐ other

Have you had any vaccination reactions, if so please explain: ________________________________

Hospitalizations (use back of page if needed):

Date	Diagnosis	Treatment	Hospital
________	____________________	______________________________	___________
________	____________________	______________________________	___________

Past Health Problems (check if you have experienced any of the following):

☐ asthma ☐ hay fever ☐ other lung disease ☐ head or spinal injuries

☐ thyroid disease ☐ other GI disease ☐ seizures or fainting ☐ kidney disease

☐ prostate trouble ☐ female trouble ☐ sinusitis ☐ arthritis

☐ heart disease ☐ high blood pressure ☐ muscle disease ☐ psychiatric disorder

☐ cancer ☐ diabetes ☐ ulcer ☐ hepatitis ☐ rheumatic fever

Family History (include parents, grandparents, brothers, sisters, etc.):

☐ high blood pressure ☐ diabetes ☐ cancer ☐ stroke ☐ TB

☐ asthma ☐ hives ☐ hay fever ☐ rashes ☐ other

Patient Name: ____

Present Health

Present Health Problems (check any you have had in the past 4-6 weeks):

- ☐ weight loss
- ☐ tremors
- ☐ problems with teeth/gums
- ☐ poor appetite
- ☐ too much appetite
- ☐ cough
- ☐ insomnia
- ☐ serious headaches
- ☐ shortness of breath
- ☐ loss of energy
- ☐ chest pain
- ☐ tight chest
- ☐ night sweats
- ☐ dizziness
- ☐ hair loss
- ☐ poor coordination
- ☐ sore throat
- ☐ chills
- ☐ earaches
- ☐ swollen feet/ankles
- ☐ rapid pulse
- ☐ fainting
- ☐ sores that don't heal
- ☐ localized weakness
- ☐ increased thirst
- ☐ blood loss

Alcohol Use: ☐ none ☐ moderate ☐ need to cut down

Street Drugs: ☐ none ☐ moderate ☐ need to cut down

Cigarettes: ☐ none ☐ moderate ☐ need to cut down

Medications (list those taken in the past 3 months):

Name of medicine and dose	Why do you take this?
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Do you have any history of reacting to medications, if so please explain: ______________________________

____

Vitamins/Supplements:

Name of vitamin or supplement	Why do you take this?
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Patient Name: ____

NAET OF Carolinas

Check if bothered by any of the following:

Eyes: ☐ itching ☐ swelling ☐ burning ☐ discharge ☐ excess tearing

Ears: ☐ itching ☐ fullness ☐ popping ☐ frequent infections

Nose: ☐ sneezing ☐ itching ☐ discharge ☐ mouth breathing ☐ runny nose

Throat: ☐ soreness ☐ postnasal discharge ☐ itching palate ☐ AM mucus

Chest: ☐ cough ☐ pain wheezing ☐ sputum ☐ shortness of breath

Skin: ☐ rash ☐ eczema ☐ psoriasis ☐ whelps ☐ cosmetics

Fumes: ☐ gasoline ☐ kerosene ☐ diesel ☐ fuel ☐ hairspray ☐ perfumes ☐ paints ☐ chemicals

☐ deodorants ☐ detergents ☐ paints ☐ insecticides

Fibers: ☐ cotton ☐ synthetics ☐ wool ☐ other ______________________________

Animal Dander: ☐ horses ☐ cats ☐ dogs ☐ other ______________________________

Insects: ☐ bees ☐ spiders ☐ fleas ☐ other ______________________________

Weather: ☐ muggy weather ☐ changes in weather ☐ cold ☐ heat ☐ air conditioning

Seasonal Allergies: ☐ flowers ☐ weeds ☐ trees ☐ grasses ☐ poison oak ☐ dust

☐ affected more in Spring ☐ affected more in Fall ☐ Spring and Fall are equally the same

Food Allergies (list any food which bothers you): ______________________________

____

Misc.: ☐ mold ☐ newspapers ☐ latex gloves ☐ smoke ☐ alcohol

Others: ______________________________

____

Patient Name: ______________________________