NAET CLINIC HEALTH FORM

Vickie Van Scyoc, RN, NAET Certified Practitioner

Date _____

Name _____ Age _____

Address _____ Email _____

_____

Phone _____ Cell _____ Work _____

Emergency Contact _____ Relationship _____

Occupation _____

How did you hear about us? _____

Primary reason you are seeking treatment _____

When did the symptoms begin? _____

Medications currently taken: _____

Vitamins, Herbs, etc. _____

Chelation, Colonics or other Detox _____

Other health professionals you are currently seeing _____

Childhood diseases _____

Immunizations _____

Hospitalizations/Surgeries - Year/Reason _____

Significant injuries or traumas _____

Any X-rays/Scans in past 2 years _____

List any known allergies _____

Have you ever had severe allergic reactions to a substance (anaphylactic shock)? Yes _____ No _____

Under stress, Memory loss, Forgetfulness, Worry _____

What are your hobbies/activities? _____

Describe your current diet _____

Coffee _____ Tea _____ Alcohol _____ Chocolate _____ Sugar _____ Cigarettes _____

Sugar Substitutes _____ Laxatives _____ Cravings _____ Aversions _____

Family History : Allergies _____ Asthma _____ Arthritis _____ Cancer _____ Diabetes _____

Heart Disease _____ Lung Disease _____ Mental Disease _____ Other (specify) _____

Any information we should know to better serve you: _____

_____