FREMONT CHIROPRACTIC CLINIC

NEW NAET PATIENT INTAKE FORM

Date _____

File # _____

Contact Information

Name_____ Referred by _____

Address_____ Employer _____

City _____ State_____ Zip_____ Work Phone _____

Phone_____ Email _____

Cell Phone Provider_____ Social Security # _____

Date of Birth _____ Age_____ Marital Status M or S Spouse Name _____

Emergency Contacts (Please list 1 family member and 1 non-family member)

Name _____ Name _____

Phone _____ Phone _____

Spouse and Children

Name _____ Age_____

Name _____ Age _____

Name _____ Age _____

Previous Chiropractic Care?

Yes__ No __ Reason _____

Yes __ No__ Reason _____

Yes__ No___ Reason _____

Medications & Supplements _____

_____

Previous Allergy Test Results_____

_____

Allergies Suspected _____

_____

Patient Initial Symptoms or Primary Concern _____

_____

Have you previously had Anaphylactic reactions to anything? Yes ____ N0 ____

Brain	Right Lung / Left Lung	Uterus/Prostate
Spleen	Physical Heart	Gallbladder
Pancreas	Emotional Heart	Liver
Left Kidney	Stomach	Large Intestine
Right Kidney	Bladder	Small Intestine

Systems Review Instructions: Fill in only the circles that apply to you.

@ O O Mild Sympstoms (occur once or twice in the past 6 months)
O @ O Moderate Symptoms (Occurred once or twwice in the last month)
O O @ Severe Symptoms (chronic, occurred once or twice in the last week)

O O O Lightheadedness
O O O Dizziness
O O O Insomnia
O O O Difficulty Concentrating
O O O Mental Sluggishness
O O O Brain Fog
O O O Headaches
O O O Migraines

O O O Chest Pain
O O O Heart Palpitations
O O O Low Blood Pressure
O O O High Blood Pressure
O O O Irregular Heart Rate
O O O Cold Hands & Feet

O O O Heartburn
O O O Greasy Food Upsets
O O O Pain b/w Shoulder Blades
O O O Nausea
O O O Gas after Meals
O O O Right Upper Abdomen Pain

O O O "Shakey" if Hungry
O O O Fatigue Relieved by Eating
O O O Afternoon Headaches
O O O Afternoon Tiredness
O O O Excessive Thirst
O O O Afternoon Headaches
O O O Afternoon Tiredness
O O O Excessive Thirst
O O O Loss of Appetite

O O O Body Aches
O O O Eye Sensitive to Light
O O O Chronic Fatigue
O O O Slow Recovery from Exercise
O O O Decreased Sex Drive
O O O Sleep Disturbances

O O O Hoarseness
O O O Chest Colds & Bronchitis
O O O Asthma
O O O Freq.Need to Clear Throat
O O O Shortness of Breath
O O O Chronic Cough
O O O Vomitting due to Cough
O O O Chest Congestion

O O O "Nervous" Stomach
O O O "Sour" Stomach
O O O Stomach Cramps
O O O Increased Appetite
O O O Decreased Aplpetite
O O O Vomitting
O O O Constipation
O O O Diarhea
O O O Gags Easily
O O O Difficulty Swallowing
O O O Bloating after Meals

O O O Light Colored Stools
O O O Sneezing Attacks
O O O Excessive Hair Loss
O O O Night Sweats
O O O Elevated Cholestrol
O O O Yeast Infections
O O O Yellowing of Skin/Eye/Nails

O O O Urine Amount Reduced
O O O Urinary Tract Infections
O O O Frequent Urination
O O O Muscle Cramps
O O O Swelling of Feet/Ankles

O O O Watery Eyes & Nose
O O O Ringing of Ears
O O O Sinus Infections
O O O Excessive Nasal Mucous

O O O Bruises Easily
O O O Dry Skin
O O O Excema
O O O Skin Rash
O O O Itchy Skin
O O O Hives

O O O Anemia
O O O Frequent Fevers

O O O Swollen Airways
O O O Food "sticking" in Chest

O O O Itchy Ears
O O O Freq. Ear Aches
O O O Ear Infections
O O O Drainage from Ears
O O O Ringing in Ears

O O O Faintness
O O O Stuttering
O O O Slurred Speech
O O O Learning Disabilities
O O O Flushing of Cheeks

FEMALES ONLY

O O O Premenstrual Tension
O O O Painful Mensus
O O O Prolonged Menstruation
O O O Missed Menses
O O O Hot Flashes

MALES ONLY

O O O Prostate Troubles
O O O Difficulty Urinating
O O O Urine Dribbling
O O O Freq. Night Urination

OTHER: (Please List)

Patient Signature_____ Date_____

Doctor Signature_____ Date_____